**SUBMITTAL TO THE BOARD OF SUPERVISORS**
**COUNTY OF RIVERSIDE, STATE OF CALIFORNIA**

**ITEM:** 3.32
(ID # 28783)
**MEETING DATE:**
Tuesday, October 07, 2025

**FROM :** RUHS-BEHAVIORAL HEALTH

**SUBJECT:** RIVERSIDE UNIVERSITY HEALTH SYSTEM - BEHAVIORAL HEALTH: Mental Health Services Act Annual Plan Update for Fiscal Year 2025/2026, All Districts. [$0].

**RECOMMENDED MOTION:** That the Board of Supervisors:

1. Adopt the Mental Health Services Act (MHSA) Annual Plan Update for Fiscal Year 2025/2026.

**ACTION:Policy**

Matthew Chang
Matthew Chang, Director 9/17/2025

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**MINUTES OF THE BOARD OF SUPERVISORS**

On motion of Supervisor Spiegel, seconded by Supervisor Gutierrez and duly carried by unanimous vote, IT WAS ORDERED that the above matter is approved as recommended.

| | |
|---|---|
| Ayes: | Medina, Spiegel, Washington, Perez, and Gutierrez |
| Nays: | None |
| Absent: | None |
| Date: | October 7, 2025 |
| xc: | RUHS-BH |

Kimberly A. Rector
Clerk of the Board
By: _____ Deputy

| FINANCIAL DATA | Current Fiscal Year: | Next Fiscal Year: | Total Cost: | Ongoing Cost |
|---|---|---|---|---|
| COST | $ 0 | $ 0 | $ 0 | $ 0 |
| NET COUNTY COST | $ 0 | $ 0 | $ 0 | $ 0 |
| SOURCE OF FUNDS: N/A | | | Budget Adjustment: No | |
| | | | For Fiscal Year: 2025/2026 | |

**C.E.O. RECOMMENDATION:** Approve

**BACKGROUND**:

**Summary**

In November 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA), which took effect on January 1, 2005. MHSA imposes a 1% tax on personal income exceeding $1 million to fund the expansion and transformation of mental health services statewide.

Pursuant to California Welfare & Institutions Code Sections 5847–5848 and Title 9 of the California Code of Regulations, Section 3310, counties are required to develop and submit a Three-Year Mental Health Services Act (MHSA) Plan, followed by Annual Updates.

Each Annual Update must be formally adopted by the Board of Supervisors prior to submission to the California Department of Health Care Services (DHCS) and the Mental Health Services Oversight and Accountability Commission (MHSOAC).

FY 2025/2026 MHSA Annual Plan Update Highlights Riverside University Health System – Behavioral Health's (RUHS-BH) continued efforts to expand and improve behavioral health services across Riverside County. The plan outlines key investments aimed at crisis response, school-based mental health, specialized outpatient care, and integrated service delivery. These initiatives are designed to enhance community well-being, promote recovery, and ensure responsible use of MHSA funding in alignment with state requirements.

Therefore, the Riverside County Board of Supervisors is requested to adopt the FY 2025/2026 MHSA Annual Plan Update to meet state requirements and authorize its submission to DHCS and MHSOAC, supporting the continued enhancement of behavioral health services in Riverside County.

**Impact on Citizens and Businesses**

Mental Health Services Act (MHSA) Annual Plan update for FY 2025/2026 outlines key initiatives by Riverside University Health System – Behavioral Health (RUHS-BH) to enhance behavioral health services and community well-being. Services under MHSA are categorized into five main categories:

1. Community Services and Supports (CSS)
2. Prevention and Early Intervention (PEI)
3. Innovation (INN)
4. Capital Facilities and Technology (CFTN)
5. Workforce Education and Training (WET)

Key Updates in these categories:

**Community Services and Supports (CSS)**

- Expanded 24/7 Mobile Crisis Response Teams countywide, diverting 70% of crisis calls from law enforcement or hospital care.
- CARE Court launched in 2023. To support program success, RUHS-BH provided BH treatment services to participants, while partnering with the court system. CARE served over 100 individuals with schizophrenia-spectrum disorders: first graduate in Dec 2024.
- 99% of peer staff certified through the Medi-Cal Peer Support Program; new "Nurturing Fathers" training launched.

**Prevention and Early Intervention (PEI)**

- Reached over 13,900 community members through mental health education and stigma reduction programs.
- Suicide bereavement counseling launched with 6–8 free sessions for survivors.
- Parenting programs (Triple P, Strengthening Families) served over 800 families; 85% program completion.
- TAY-focused programs served over 200 youth with strong outcomes in depression reduction and school engagement.
- Older adult depression services served 400+ clients with improved quality of life.
- Trauma-based school interventions (CBITS) served 300+ youth.
- New engagement efforts launched to redesign culturally relevant services for African American communities.

**Innovation (INN)**

- Completed Help@Hand tech-based mental health initiative; 8 of 9 projects integrated into core services.
- Key successes include DHoH peer support, TakeMyHand™ peer chat, and Whole Person Health Score screenings (58,000+).
- New $29M Innovation Plan launched: The Mindful Body and Recovery Program, focusing on eating disorder treatment and training.

**Capital Facilities and Technology Needs (CFTN)**

- Mead Valley Wellness Village under construction anticipated to be completed by December 2026.
- Renovated 84-bed adult residential facility in Riverside with full-service treatment available onsite.

**Workforce Education and Training (WET)**

- Provided 158 training courses to over 2,600 participants; culturally competent and safety-focused education emphasized.
- Expanded recruitment through outreach events reaching 2,200+ students.

**Additional Fiscal Information**

No funds are required to adopt the MHSA Plan update.

**Attachments**

Attachment A. 2025.2026 MHSA Plan Annual Update

Jacqueline Ruiz
Jacqueline Ruiz, Principal Analyst 9/30/2025

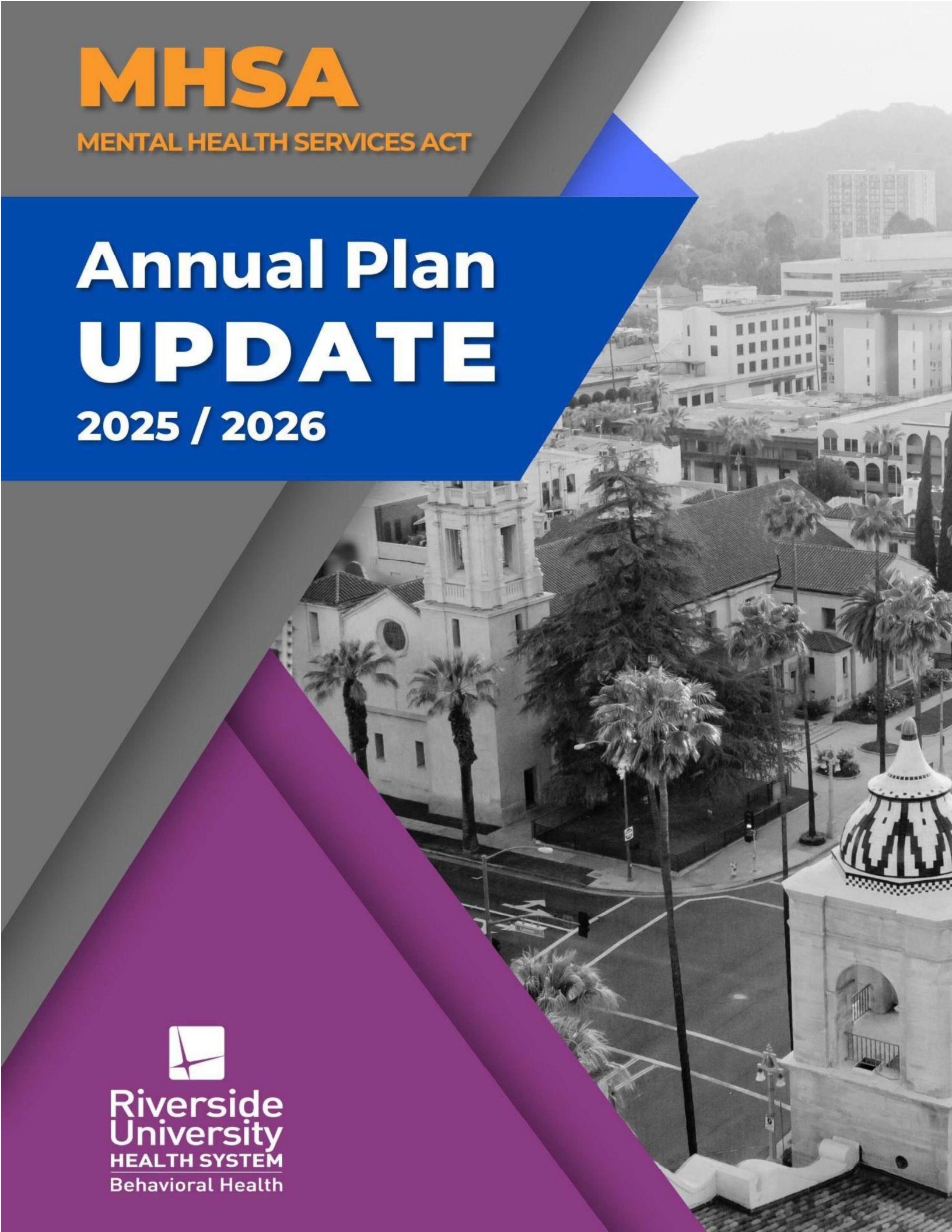
Gregg Gu
Gregg Gu, Chief of Deputy County Counsel 9/17/2025

# MHSA

MENTAL HEALTH SERVICES ACT

# Annual Plan UPDATE

## 2025 / 2026



Riverside University HEALTH SYSTEM Behavioral Health

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# Land Acknowledgement[1]

***Land Acknowledgement***

**The Cahuilla (Íviullatem), Cupeño (Kúupangaxwichem), Luiseño (Payómkowichum), Serrano (Marra'yam), Gabrieleño (Tongva), and Chemehuevi (Nuwuvi) Peoples, and their ancestors have been here since time immemorial. Riverside University Health System-Behavioral Health (RUHS-BH) acknowledges the traditional, ancestral, and contemporary homelands of the first Native Americans of Southern California whose land it occupies and serves. The Cahuilla, Cupeño, Luiseño, Serrano, Gabrieleño, and Chemehuevi Peoples have cared for people, land, water bodies, animals, plant beings, with great integrity, reciprocating care to each other.**

**RUHS-BH acknowledges the reciprocal relationship of caring for one another and extends wellness and behavioral health services to: Cahuilla, Cupeño, Luiseño, Serrano, Gabrieleño, and Chemehuevi Peoples, all Indigenous Peoples, and all underserved residents of Riverside County.**

**RUHS-BH wants to create relationships built on trust and accountability with its community members. With this land acknowledgment, RUHS-BH will be respectful and mindful to tribal sovereignty, culture, and beliefs of the Native Americans of this land.**



[1] Land acknowledgment was developed by Dr. Sean Milanovich the Cultural Community Liaison for Cultural Community Program

# MHSA County Compliance Certification

## MHSA COUNTY COMPLIANCE CERTIFICATION

County: Riverside County

| Local Mental Health Director | Program Lead |
|---|---|
| Name: Matthew Chang, MD. | Name: David Schoelen |
| Telephone Number: 951-358-4501 | Telephone Number: 951-955-7106 |
| E-mail: Matthew.chang@ruhealth.org | E-mail: DSchoelen@ruhealth.org |
| County Mental Health Mailing Address: 4095 County Circle Drive Riverside, CA 92503 | |

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this annual update, including stakeholder participation and nonsupplantation requirements.

This annual update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on _____.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached annual update are true and correct.

Matthew Chang, MD.

Local Mental Health Director/Designee (PRINT)

Signature

Date

County: Riverside

Date: 5/15/25

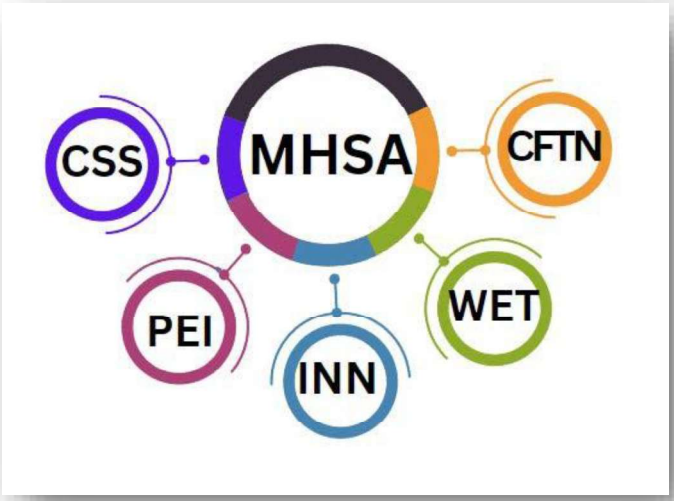
# Introduction

## MHSA QUICK LOOK

What is the Mental Health Services Act (MHSA)?

The Mental Health Services Act (MHSA) was a ballot measure passed by California voters in November 2004 that provided specific funding for public mental health services. The Act imposed a 1% taxation on personal income exceeding $1 million. This funding provided for an expansion and transformation of the public mental health system with the expectation to achieve results such as a reduction in incarcerations, school failures, unemployment, and homelessness for individuals with severe mental illness.

The programs funded through MHSA must include services for all ages: Children (0 - 15), Transition Age Youth (16-25), Adults (26-59), and Older Adults (60+). Though program implementation may be integrated into the Department's existing




management structure, the MHSA Administrative unit manages the planning activities related to the five MHSA components, which are:

1. Community Services and Supports (CSS)
2. Prevention and Early Intervention (PEI)
3. Innovation (INN)
4. Workforce Education and Training (WET)
5. Capital Facilities and Technology (CFTN)

MHSA funds cannot be used to supplant programs that existed before November 2004.

The primary components of MHSA are CSS and PEI. These two components receive active funding allocations based on the State distribution formula. INN funds are

derived from a portion of the CSS and PEI allocations and require an additional State approval process to access. WET funds were a one-time allocation that could last for 10 years; those funds have been exhausted, and ongoing WET Plan funding is derived from the CSS allocation. The last CF/TN funds were allocated in the Fiscal Year. Some funds—called a Prudent Reserve—can also be saved as a rainy-day fund to sustain programming during periods of economic fluctuation that impact this tax revenue.

**Where does MHSA fit in funding Riverside University Health System – Behavioral Health (RUHS-BH)?**

MHSA is only one of the funding streams for RUHS-BH. The MHSA Plan does not represent all public behavioral health services in Riverside County and is not meant to serve as a guide to all service options. Not all services can be funded under MHSA.

**What is the purpose of MHSA's 3-year Program and Expenditure Plan (3YPE)?**

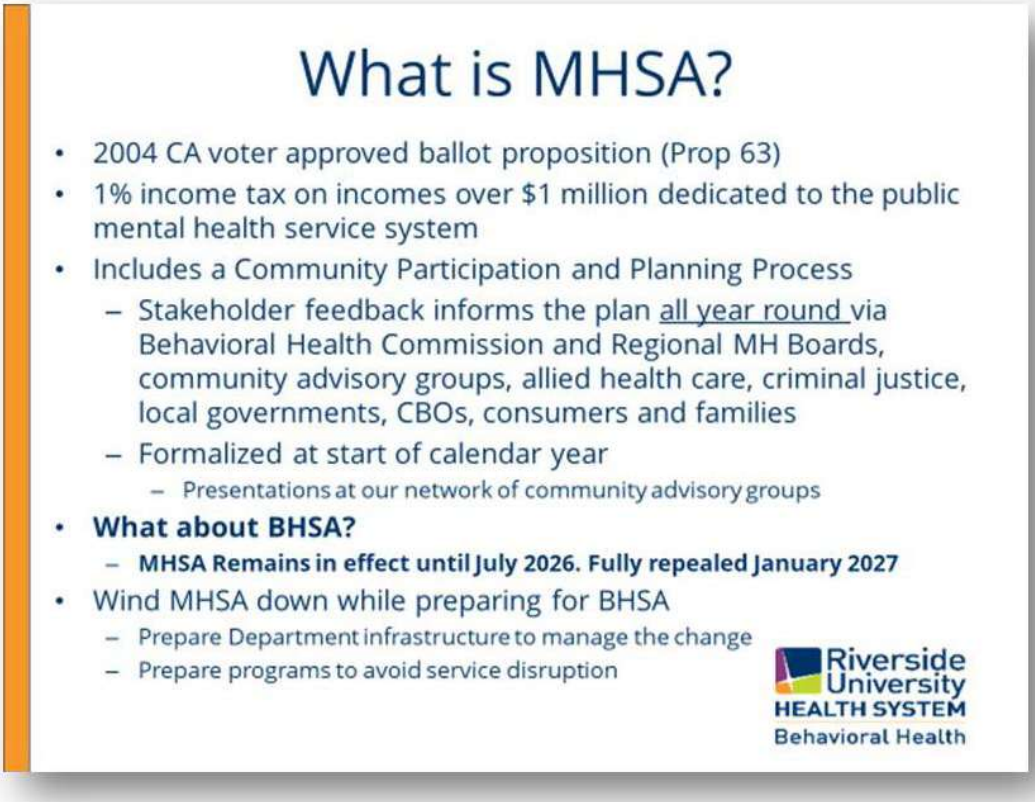
The 3YPE serves like a consumer's care plan in a clinic program. It describes goals, objectives, and interventions based on the stakeholder feedback and the possibilities and limits defined in State regulations.

Every three years, Riverside County is required to develop a new Program and Expenditure Plan for MHSA. The 3YPE outlines and updates the programs and services to be funded by MHSA and creates a new three-year budget plan. It also allows the County to re-evaluate programs and analyze performance outcomes to ensure the services being funded by MHSA are effective. A single fiscal year begins on July 1st and ends the following calendar year on June 30th. The current 3-year plan is dated FY 23/24 – FY 25/26 and was approved last year. This will be the final MHSA 3-year plan before the new Behavioral Health Services Act (BHSA) Plan is due in July 2026.

**What is an Annual Update?**

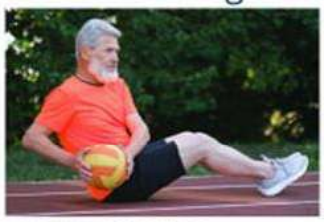
MHSA regulations require counties to provide community stakeholders with an update to the MHSA 3YPE on an annual basis and provide education on MHSA regulation, the act, and the components. Therefore, Riverside County engages community stakeholders by providing them with an update on the programs being funded in the 3YPE and foundational knowledge on MHSA's mission, purpose, and compliance. The community process allows stakeholders to provide feedback from their unique perspectives about the programs and services being funded through MHSA. This year's plan is an Annual Update.

***Annual MHSA Education PowerPoint***



## What is the MHSA Plan?

- A big report that goes to the Board of Supervisors and State Department of Health Care Services
- Authorizes MHSA expenditures
- Provides progress and outcomes on existing MHSA funded programs
- Two types of MHSA plans
  - 3-Year-Plan (FY 23/24 -25/26)
  - **Annual Update**



Riverside University HEALTH SYSTEM Behavioral Health

## MHSA Frame

- 5 Components:

1. Community Services and Supports **(CSS)**
2. Prevention and Early Intervention **(PEI)**
3. Innovation **(INN)**
4. Workforce Education and Training **(WET)**
5. Capital Facilities and Technology **(CFTN)**

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## CSS

- Largest Component – 76%
- Includes Full Service Partnerships (FSP), Housing/HHOPE, Crisis System of Care, and Mental Health Courts/Justice Involved programs, Peer programs

## PEI

- Next largest component – 19%
- Reduce stigma related to seeking services, reduce discrimination against people with a diagnosis, prevent onset of a SMI
- Early intervention for people with symptoms for 1 year or less or do not meet criteria for a diagnosis; low intensity, short term intervention

Riverside University HEALTH SYSTEM Behavioral Health

## Riverside Co CSS and PEI Highlights

- Our crisis system of care includes 24/7 crisis support center (951-686-HELP) providing access to our around-the-clock BH mobile crisis teams, and 3 regional 24/7 walk-in Mental Health Urgent Care clinics (Riverside, Perris and Palm Springs).
- Community Assistance, Recovery, and Empowerment Act, known as CARE Court, launched in 10/2023. This collaborative court team serves consumers with schizophrenia spectrum disorders who are court ordered into supportive treatment. The program celebrated its first graduate in 12/2024; one of the first graduations in the State! As of 01/2025, over 400 people were referred and 116 became clients.
- PEI funded Suicide Prevention Coalition pioneered clinical bereavement support for survivors of suicide loss. Community based therapists were trained using a manual developed specifically for Riverside County by Dr. Sally Spencer-Thomas, a nationally recognized leader in the field. Sessions are no-cost for participants. Additionally, in partnership with American Foundation of Suicide Prevention, community volunteers were trained to facilitate suicide loss support groups, which were nearly non-existent before this initiative.

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## INN

- Funded out of 4% CSS and 1% PEI
- Used to create "research projects" that advance knowledge in the field; not just fill service gaps
- Time limited: 3-5 years
- Requires additional State approval process to access funds

## WET

- Funded from a portion of CSS dollars.
- Recruit, retain, and develop the public behavioral health workforce

## CF/TN

- Funded from a portion of CSS dollars
- Improve the infrastructure of public mental health services: buildings and electronic programs.

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## Riverside Co INN, WET & CFTN Highlights

- In 02/2024, MHSA Admin successfully completed the State review process to receive $29M MHSA Innovation plan funds for the Mindful Body and Recovery Program, an eating disorder intensive outpatient and education program. This level of care had missing in public BH. Early implementation started in 09/2024.
- WET centrally coordinates one of the largest BH internship programs in the IE. Last year, WET received 120 applications and accepted 37 MA and BA students from 10 different universities. 42% were bilingual with over 50% being Spanish speakers. RUHS-BH hires a majority of the graduates.
- Renovation is complete on an augmented adult residential care facility on Franklin Ave. in the City of Riverside. The facility has 84 beds and integrated, on-site FSP services. Facility is scheduled to open 03/2025.
- Mead Valley Wellness Village broke ground in 2024! The Village is a campus of BH services providing a continuum of BH care from outpatient to residential in a single location. In addition, the village will provide some physical health care services and employment support.

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## What's Next for Community Stakeholders?

### Public Posting & Hearings

- **April 2024 : 30 day website posting**
  - Give written feedback on draft plan
- **May 2024: Public Hearings**
  - Provide your opinion to the BHC
  - In-person: MIMHM
    - May 01 Desert
    - May 08 Mid-Co
    - May 15 Western
  - Virtual 24/7 videos on-line

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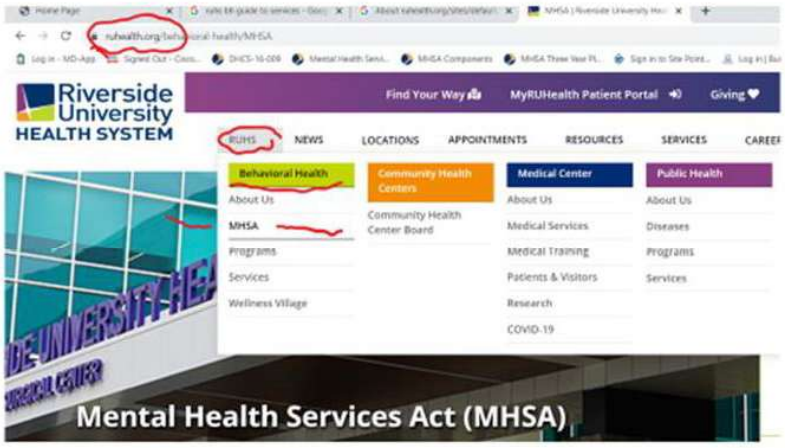
Behavioral Health

## ruhealth.org

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Behavioral Health

## Does my feedback do anything?

- Yes! Does every comment lead to a change? No.
- Staying and being informed helps. Asking questions is encouraged.
- Understand the BH Continuum of Care that is already offered. Be as specific as you can about what you like or what you'd like to see changed.
- Connect to a Department advisory group so your voice can be amplified:
  - Behavioral Health Commission and related committees, MH Regional Boards
  - Cultural Competency Reducing Disparities and related community subcommittees
  - PEI and regional TAY collaboratives

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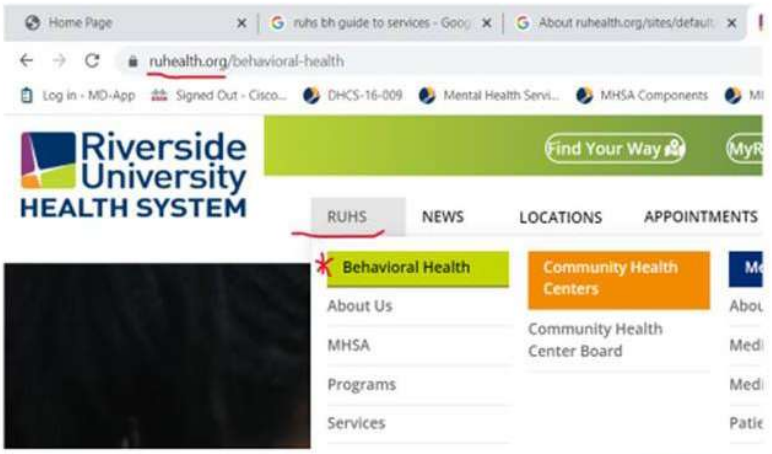
## ruhealth.org

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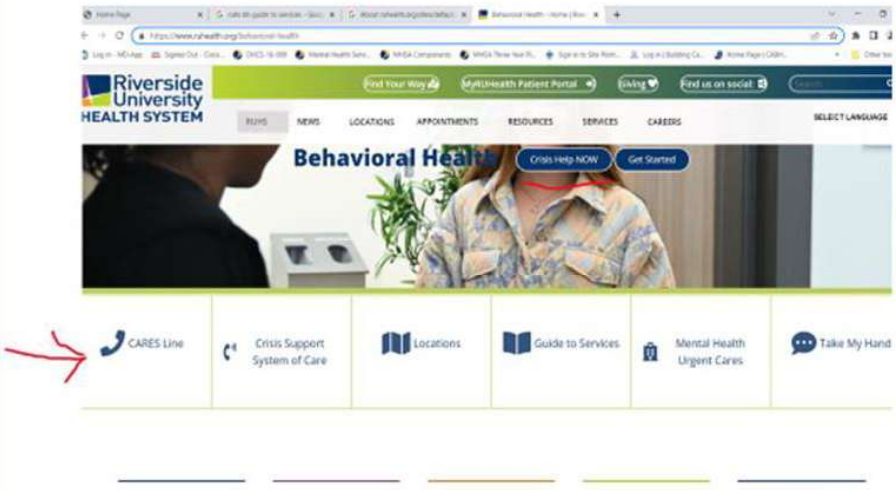
## ruhealth.org/behavioral-health




Riverside University HEALTH SYSTEM
Behavioral Health

## Contact Info

Sign Up for Email Notifications

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- WET: Nisha Elliott
  - NElliott@ruhealth.org
  - WET@ruhealth.org
- INN: (Planning lead) Leah Newell
  - LMNewell@ruhealth.org
  - bhculturalcomp@ruhealth.org

Riverside University HEALTH SYSTEM
Behavioral Health

Introduction

## What is BHSA?

- Behavioral Health Services Act (BHSA)
- Proposition 1 (March 2024 ballot)
  - Became law January 2025
  - Prop 1 also included $6.4 billion bond for BH residential care and supportive housing
  - Embedded timelines: 1st new Integrated Plan 7/2026
- Not just a MHSA crosswalk. New components, regulations, reporting, and oversight.

Riverside University HEALTH SYSTEM Behavioral Health

## The BHT Process

State guidance, direction, and legislative refinement is currently, actively being developed.

This is a slow-going process that includes dialogue between State and Counties to negotiate how the laws will be applied.

Some of what is presented today may change with future State updates.

Riverside University HEALTH SYSTEM Behavioral Health

## Guiding Principles Change

| MHSA | BHSA |
|---|---|
| • Funds of last resort. Can be used for non-billable services | • Still funds of last resort, but prioritize Medi-Cal and commercial payor billing |
| • Strong focus on peer support and MH recovery | • Focus on homelessness, especially encampments |
| • County had more independence | • State has more oversight |
| • Serious Mental Illness (SMI) | • SMI AND Serious SUD |
| • Reach people before they have consequences of SMI and promote MH recovery | • Address the consequences of untreated BH disorders and prevent exacerbation |
| • Early Intervention designed to prevent onset of SMI | • Early intervention designed to prevent disorders from becoming severe and disabling. |
| • Outreach based on stigma reduction, education, and awareness | • Outreach based on connecting people to care |

Riverside University HEALTH SYSTEM Behavioral Health

## Planning and Reporting Changes

| MHSA | BHSA |
|---|---|
| • Annual Community Planning and Participation Process (CPPP) | • CPPP every 3 years but mandates list of stakeholders to include 5 largest cities, local health jurisdictions, manage care plans |
| • Each county set own goals | • State to define success metrics |
| • County had no EBP restrictions | • State to provide menu of approved EBP and CDEBP for program model |
| • Component funding percentages were rigid | • Funds can be moved between components with State approval |
| • Prudent reserve max is 33% of CSS | • Prudent reserve max is 20% of total |
| • Report contained only programs and budget for MHSA funds | • Report contains ALL BH funds |
| • No strong sanctions for non - compliance | • State can direct plan revisions and provide sanctions |
| • Annual Review and Expenditure Report (ARER) | • Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR) |

Riverside University HEALTH SYSTEM Behavioral Health

# Component Changes

## MHSA

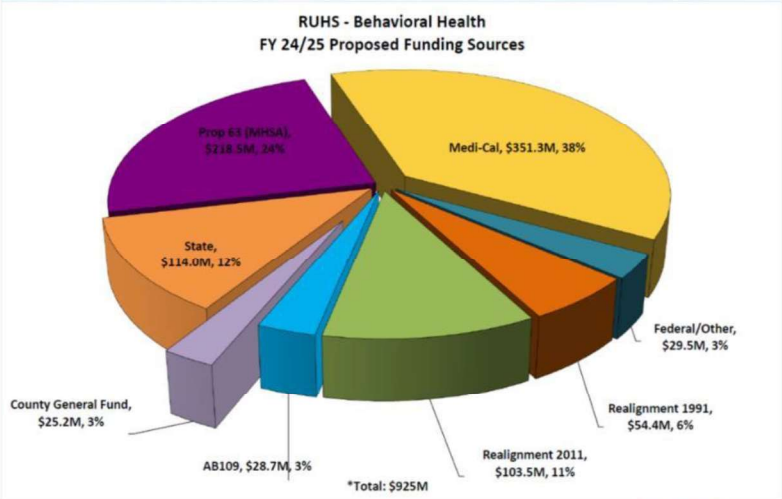
- State Allocation: 5% OTT
  - Admin costs
- CSS: 76%
  - FSP
  - GSD, Crisis, Criminal Justice,
  - Outreach and Peer Programs
  - Housing
- PEI: 19% (51% on youth < 25)
  - Prevention
  - Early Intervention
- INN: 5%
  - Encumbered funds good through life of current ED-IOP plan 2029
- WET (funds from CSS)
- CFTN (funds from CSS)

## BHSA

- State Allocation: 10% OTT
  - Population based Prevention
  - INN partnership fund
  - Workforce initiatives
  - Admin costs
- Housing: 30%
  - No treatment, support svs
  - Includes (CFTN) housing developments
- FSP: 35%
- BHS: 35%
  - Early Intervention (50%)
    - Definition change
    - 51% on youth < 25
  - WET, INN, CFTN (except housing)

Riverside University HEALTH SYSTEM Behavioral Health

# RUHS-BH Funding Sources




Riverside University HEALTH SYSTEM Behavioral Health

## Where is Riverside's BHT at?

- Key Department leadership attend workgroups with California Behavioral Health Directors Association (CBHDA)
- State has released two Behavioral Health Transformation policy manual modules in late 2024. More to come.
- Department created a BHT Workgroup:
  - Creating an internal timeline
  - Unbraiding MHSA funds to help understand which programs are at most risk based on BHSA regulations and community priorities
  - Develop and plan for the new expanded stakeholder process
  - Transform MHSA Admin into BHSA Admin
  - Prepare for the new reporting procedure and document

Riverside University HEALTH SYSTEM Behavioral Health

## BHSA Timeline

### By June 30, 2026

- Board of Supervisors approves FY 26-29 Integrated Plan
- Submit FY 26-29 Integrated Plan to DHCS and BHSOAC

### July 01, 2026

- FY 26-29 Integrated Plan becomes effective

### June 30, 2027

- FY 27/28 Annual Update is due

### January 20, 2029

- FY 26/27 BH Outcomes, Accountability, and Transparency report is due

Riverside University HEALTH SYSTEM Behavioral Health

# Introduction

## *MHSA Plan Highlights Fiscal Year 25/26*

### *Community Services and Supports (CSS)*

General System Development

- Riverside County Mobile Crisis Response for Behavioral Health is now available 24/7. The Mobile Crisis Teams include clinical therapists, case managers, addiction counselors, and peer support specialists. This team is dispatched where the behavioral health crisis is occurring with the goal to deescalate the situation, link to ongoing care, and avoid unnecessary emergency department care, psychiatric hospitalizations, and law enforcement involvement. The Mobile Crisis Teams are countywide, and have successfully diverted 70% of contacts from law enforcement and inpatient admissions, demonstrating their effectiveness in handling crises without traditional enforcement methods. The Mobile Crisis Teams can be accessed by calling 951-686-HELP

- Community Assistance, Recovery, and Empowerment (CARE) Act more commonly known as CARE Court launched in October 2023. RUHS-BH provides behavioral health engagement, assessment, care planning, linkage, and wraparound case management services to consumers with schizophrenia spectrum disorders who are court ordered to engage in supportive treatment. The program celebrated its first graduate in 12/2024; one of the first graduations in the State! As of 01/2025, over 400 people were referred and 116 became clients.

Peer Support Service

- Peer Administration successfully supported RUHS-BH Peer Support employees to pass the Medi-Cal Peer Support Certification Program. 99% of incumbent peer employees have successfully completed the certification process.

- Parent Support and Training successfully implemented a new training support for fathers called, “Nurturing Fathers.” The program includes individual and group sessions

### *Prevention and Early Intervention (PEI)*

The intent of Prevention & Early Intervention is to engage individuals before the development of serious mental illness or serious emotional disturbance or to alleviate the need for additional or extended mental health treatment. There are seven work plans with several programs and services in each. PEI providers continued to show success in meeting program goals and objectives and reaching the target populations.

**Work Plan 1**: Mental Health Outreach, Awareness, and Stigma Reduction – includes several different strategies that focus on mental health stigma reduction, education about mental health symptoms, and increasing access for underserved communities.

- The Community Mental Health Promoter programs focus on target populations including Latino/a/x, Native American, Asian/PI, and Middle Eastern/North African. Providers engaged with 13,973 community members delivering 3,666 1-hour presentations with information about: anxiety, depression, mental health, schizophrenia, self-care, substance abuse, suicide prevention, trauma, and bipolar disorder.

- PEI Administration continued to offer trainings, virtually and in-person, available to the general community focused on mental health awareness, self-care and wellness, trauma and resiliency, and suicide prevention. Additionally, in-person suicide prevention trainings were offered throughout the fiscal year. Trainings are free and available every month. In total for FY 23/24 1,506 participants attended the 91 trainings that were offered.

- PEI, in partnership with the Suicide Prevention Coalition, has launched short-term grief counseling for survivors of suicide loss at no cost to residents of Riverside County. This pilot project will offer 6-8 free sessions to suicide loss survivors through community-based clinicians who are trained in a specific approach to support suicide bereavement. PEI partnered with IEHP and Molina to train several of their providers to offer this as a benefit to their members. Suicide Loss survivors can request this service by visiting the TIP website at: https://tiprivco.org/bereavement-counseling/.

**Work plan 2**: Parent Education and Support—includes services that assist parents and families in building protective factors and reducing their risk of developing mental health problems.

- The Triple P program offers a multi-level system of parenting and family support strategies for families with children aged 2-12 and for families with teens aged 12-16. Triple P is designed to prevent children's social, emotional, behavioral, and developmental problems by enhancing their parents' knowledge, skills, and confidence. Teen Triple P aims to promote positive, caring relationships between parents and their teens and to help parents develop effective management strategies for dealing with a variety of teen behavior problems and common developmental issues. During FY23/24, the provider for this program increased their services, aiming for twice the numbers served to better meet community need. They nearly met that goal for this fiscal year, serving 686 families countywide.

- The Strengthening Families Program is an evidence-based program that emphasizes the importance of strong family relationships and building family resiliency. The program seeks to make family life less stressful and reduce family risk factors for behavioral, emotional, academic, and social problems in children. This program brings together families for 14 weeks, for 2 ½ hours each week. In FY23/24 the program served 117 families with 144 parents attending with an 85% completion rate; 80% were Hispanic/Latinx.

**Work plan 4:** Transition Age Youth – outreach, stigma reduction, and suicide prevention activities for (TAY) at highest risk of self-harm. This includes targeted outreach for LGBTQ TAY, TAY in or transitioning out of the foster care system, runaway TAY, and TAY transitioning into college.

- The Directing Change Statewide Program and Film Contest for FY23/24 included 203 Film Submissions from 26 schools & CBOs by 580 youth. The partnerships with RCOE and RUHS-PH continued to make the event a success. In addition, a local rotary was able to sponsor the event, contributing to cash prizes for this year's winners. Riverside County's Eleanor Roosevelt High School won 1st place in the Suicide Prevention Category titled "Speaking Up" for both our local recognition ceremony and the statewide contest. The Riverside County recognition ceremony also featured an Art Gallery Walk, recognizing the youth who submitted and won the state's monthly Hope & Justice contests throughout the academic year.

- Stress and Your Mood is an evidence-based early intervention program used to treat transition-age youth who are experiencing depression. In FY23/24, the program served 244 TAY with 68% completion. Outcomes include a statistically significant reduction in depression, and all participants showed improvement overall.

**Workplan 5**: First Onset for Older Adults - includes services to reduce the first onset of depression and to reduce the impact of depression in the older adult population.

- The programs within this work plan include Cognitive Behavioral Therapy for Late-Life Depression (CBTLLD), Program to Encourage Active Rewarding Lives for Seniors (PEARLS), and partnership with the Riverside County Office on Aging to deliver Caregiver Support Groups, Healthy IDEAS, and mental health liaisons to assist Office on Aging staff via consultation, outreach, and early intervention service delivery. These programs served 403 participants with overall reductions in depression and anxiety along with improved quality of life.

Workplan 6: Trauma-Exposed Services – provides services to reduce the negative impact of trauma for individuals, families, and the behavioral health service system.

- Cognitive Behavioral Intervention for Trauma in Schools (CBITS) is a school-based group intervention (for grades 5-12) that has been shown to reduce PTSD and depression symptoms and psychosocial dysfunction in children who have experienced trauma. CBITS served 313 youth with 84% completion. Outcomes include improvement in depressive symptoms and 64% of youth trauma symptoms dropped below clinical significance. Bounce Back is an adaptation of the CBITS model for elementary school students (K-5). This adaptation is currently out for competitive bid.

**Work plan 7**: Underserved Cultural Programs—This work plan includes programming for each of Riverside County's underserved ethnic populations. The programs include evidence-based and evidence-informed practices that are effective with the populations identified for implementation.

- Building Resilience in African American Families project (BRAAF) utilized a multi-intervention strategy with the primary program goals of reducing the risk of developing mental health problems and increasing resiliency and skill development for the African American population in Riverside County who are most at risk of developing mental health issues. This program faced many challenges over the years regarding program recruitment, retention, and fidelity to the program curriculums. After strategic supports, additional trainings, and technical assistance, it was determined that this program was no longer meeting the needs of the African American community in Riverside County. Furthermore, it was determined by community stakeholders that the County needs to understand better what the current needs are of this underserved population. Currently, we are in the competitive bid process for a Qualitative Community Engagement Project to select a culturally specialized research agency that can assist with conducting a comprehensive and strategic community needs assessment to inform the development of more appropriate programs and supports for the African American population in Riverside County across the continuum of behavioral healthcare.

- Mothers & Babies/Mamás y Bebés: The Mothers & Babies program worked to increase engagement and service delivery to African American women throughout Riverside County. For FY23/24, the program served 255 women with 91% completion, 83% served were Latina, and 3.5% were African American; overall outcomes showed a statistically significant reduction in depressive symptoms. All three contract providers actively increase strategic outreach and partner with other African American serving organizations/workgroups, including the Perinatal Equity Initiative and The Amani Project. One of the providers, Riverside Community Health Foundation, is aiming to further this work by holding a focus group with previous African American participants to learn from them how to make the curriculum more culturally relevant and will be piloting a group for African American moms lead by African American facilitators, that will incorporate the feedback from the focus group.

***Innovation (INN)***

- Our 5-year Innovation Plan, **Help@Hand** (Help at Hand), ended in February 2024. The Help at Hand Innovation Plan explored the best ways to bring technology-based mental health tools into the public mental health service system. Riverside County planned and implemented nine (9) projects aligned with the initial goals and objectives. Eight of the nine projects have been transitioned into our standard system of care to continue serving the Riverside County community, with the ninth continuing

to inform our work with the Deaf and Hard-of-Hearing Community (DHoH). Information on the Help at Hand project can be accessed at **https://HelpatHand.info**. Highlights from the H@H project include:

**DHoH—Riverside County's needs assessment and resulting work have** provided a path for learning about DHoH community needs and how to help them better access mental health services technology. The information generated by this effort makes an invaluable contribution to one of Riverside's diverse communities.

1. I translated the Digital Mental Health Literacy (DMHL) video series on the Help@Hand website in ASL and found that the DHOH community benefited.
2. Launched a needs assessment survey to gain more insight into the specific needs of the DHoH community.
3. Administered ASL-inclusive Peer Support Specialist Training, with two participants completing the course and eligible for the Medi-Cal certification exam.
4. Launched the Peer-supported TakemyHand video chat pilot using Peer Support Specialists who are deaf or hard of hearing.
5. Riverside adapted the DHoH Needs Assessment so that other Collaborative members could adopt and use to tool in their own communities
6. Help at Hand will produce two research papers in collaboration with UCI. The first, Understanding the Potential of Mental Health Apps to Address Mental Health Needs of the Deaf and Hard of Hearing Community: Mixed Methods Study, was published on November 11, 2022. The second is set for publication later this year. These research publications contribute to advancing knowledge in digital mental health technology for the DHoH community, provide educational value to other research organizations, and can help inform public policy and decision-making, ultimately driving societal improvements.

**TakemyHand™ -** The Live Peer Chat is now under RUHS BH Peer Support Services, and continues to provide free, peer-to-peer live chat interface using real-time conversations for individuals 16 or older seeking non-crisis emotional support. It remains available online at TakeMyHand.co. or TomamiMano.co for Spanish speakers and via iPhone and Android Apps.

1. The mobile app was approved by Google Play in 2024
2. The Emotional Wellness Check-In Tracker feature was added to the mobile app
3. Univision/NBC Interviews created and ran TV campaigns in https://vimeo.com/showcase/11106848 (English) and https://vimeo.com/showcase/11106895 (Spanish).
4. Between 2021 – 2023, Total users ranged from 5,362-33.4 K and total sessions from 4,867 – 39.4 K.

**La CLAve -** a mental health awareness education program created to help individuals and their families recognize the symptoms of serious mental illness, was well-embraced by the community. This program continues as part of the Prevention and Early intervention plan.

1. Univision/NBC Interviews and "Break Stigma" videos promoted La CLAve in the Desert region to educate and help reduce stigma in the desert community, which has a large percentage of Spanish-speaking residents: https://vimeo.com/showcase/11106748 (English) and https://vimeo.com/showcase/11106770 (Spanish)
2. The Prodromal Questionnaire Brief (PQB) was integrated into the TakemyHand™ website and mobile app under the Learn La CLAve section.
3. Riverside realized the benefits of its efforts by the end of 2024 with 52,952 engagements.

**Man Therapy -** a mental health engagement campaign geared specifically for men was also well-embraced by the community. This program also continues as part of the Prevention and Early intervention plan. Man Therapy also now has an active Spanish website option that went live in February 2024.

1. The Spanish website went live in February 2024.
2. By the end of 2023, the partnership supported 56,444 participants through 64,889 website sessions and completed 16,033 screenings for users from Riverside County.
3. Riverside grassroots efforts reached other community members outside the county with 26,692 screenings completed in California.

**The App for Independence or A4i** - a mobile app used to support the recovery process of individuals living with schizophrenia or psychosis is now also managed under Peer Support Services.

1. Piloted over two (2) years for high-risk populations such as adults, older adults, and transitional aged youth (TAY)
2. For more information visit the Hearts Showcase website: https://vimeo.com/showcase/11000292
3. An animated video was created in partnership with Dreamsyte to encourage adoption of the A4i app among the pilot participants A4i Animated Video

T**he Whole Person Health Score** - a screening tool that can help a person and their health care team determine areas of health strength and risk across six domains: physical health, emotional health, resource utilization, socioeconomics, ownership, and nutrition and lifestyle. Our Help @ Hand partners separately assisted in the digitization for virtual platforms and validation of the tool, ensuring a reliable measure that is easily accessible by the community and their healthcare providers.

1. Initially, the tool was digitized to facilitate a survey assessment
    a. The tool was distributed by three different departments: Medical Center/Community Clinics, Behavioral Health, and RivCoONE
    b. The 28-question assessment provides a "snapshot" of an individual's health

    c. There were 1,863 WPHS assessments completed during February 2023 and February 2024: MC/CC (301); BH (1,066); RivCoONE (496)
2. Later, the holistic, patient-centered adult tool developed by RUHS was validated to evaluate the measurement performance of WPHS domain and composite scores
    a. The analytic sample included 58,055 patients who completed at least one WPHS survey between August 2019 and February 2024.
    b. The dataset included demographic and clinical characteristics, WPHS responses and scores, types of clinical visits, and diagnosis indicators of chronic health conditions.
    c. data quality assessment provided actionable recommendations for further refinement and implementation.
    d. Further evaluation is encouraged to ensure the WPHS continues to evolve as a valuable tool for patient-centered care and quality improvement within RUHS.

90 interactive **Kiosks**, installed in waiting areas throughout Riverside County, provided a wide range of information on healthcare access.

1. Kiosks were deployed in clinics and community organizations across the different geographic regions
2. A kiosk locator is present on the H@H website to help consumers find where to learn more about available resources via the closest kiosk
3. They remain active as points of service navigation and education for people seeking care.

The **Recovery Record App assists with eating disorder management and was** piloted as part of the Help at Hand Innovation project.

1. Providers that worked with clients using Recovery Record found it easy to use and valuable in tracking client emotions and behaviors.
2. This eating disorder tracking and support mobile app continues to be utilized as a part of the new Eating Disorder Innovation project.

**Help@Hand Summary project -** Here is the story map with the latest **numbers** related to the 2024 reporting period. “Transforming Emotional Wellness across Riverside County and beyond with Technology”: https://arcg.is/1SW0Dz

- As Help@Hand ended, a new plan began. Over the past year, we have actively shaped a new Riverside County Innovation plan, an Eating Disorder Intensive Outpatient and Training Program, entitled **The Mindful Body and Recovery Program**. This Five-Year, $29 Million plan was approved by the State in February 2024. Designed to address the challenges of treating eating disorders, this project is creating an Eating Disorder Hub where we can examine how to best treat, train, and educate our Riverside County Community through an integrated care approach.
    - The Intensive Outpatient Program (IOP) will serve adolescents ages 12 to 18 years old who require this higher level of care. This project aims to address

the critical need for improved treatment and care for individuals with eating disorders, which have the second-highest mortality rate among mental health conditions. By focusing on enhancing treatment practices, increasing access for underserved populations, and raising community awareness, we aim to improve both the quality and availability of care. This approach includes training practitioners and providing a level of care previously non-existent in public behavioral health.

***Workforce Education and Training (WET)***

- The department is invested in having well trained paraprofessionals and professionals thus offering trainings department wide and to our contracted providers. Also supporting community members and retirees to be trained. In the last year 158 trainings were offered, which was an increase from the 98 trainings that were offered the previous year. Collectively 402 continuing education (CE) units were provided. 2,646 attendees were trained. Trainings offered were, Cognitive Behavioral Therapy for PTSD, Dialectical Behavioral therapy, Lehman center lead Square Model Training which was revised to be consistent with Cal AIM. Trainings on Suicide Harm and Trauma as well as Seeking Safety in which there were 79 staff trained this year. In addition, Lehman offered competency trainings for Clinical Supervisor. Culturally specific trainings were offered such as Disability Training for the Generalist Clinician and Gender Affirming Care. Staff safety is important thus 16 NCI trainings were offered and 332 staff were trained which was an increase from 267 the previous year. Lastly, Lehman center has provided trainings to the TOPPS program in connection with Hemet Unified School District.

- Recruitment outreach efforts increased reaching approximately 2,205 students and community members, inclusive of two outreach events called, Get Psyched, that were in collaboration with Vista Del Lago High School and Moreno Valley College reaching 200 Highschool students and secondly, the first Get Psyched event in Palm Desert reaching approximately 230 high school students. Both events centered on the education and career pathways into public behavioral health service system. Also, as it relates to students, provided support doing Mock interviews with the school's health academy programs. WET/Lehman programs have participated in May is Mental Health Month Fair at Fairmount Park and Indio, public forum for the Mental Health Service Act (MHSA) plan, the Norco College Health, Wellness, and Safety Fair, supported other programs by participating in the Directing Change event and Lehman participated in a community focused Halloween Drive Thru Event.

- Retention is important. To support pre-licensed clinical workforce, CLAS has been expanding its services and increased applicants from 29 last year to 31 this year. 24 Clinical Licensure Advancement and Support (CLAS) participants became licensed and promoted to Clinical Therapist II (CTII) positions which was an increase from 16 last

year. The Lehman Center and WET staff have provided clinical supervision. Also, WET acquired a grant from Kaiser Permanente which funding would offset staff salary, support in hiring diverse staff, and unlicensed staff to achieve licensure. Lehman Senior CTs have offered clinical support to clinical supervisors, provide group supervision, and oversee interns. The program also provided coaching/mentoring to managers and supervisors. WET is in full implementation of the centralized support program for Clinical Supervisors to be able to ensure consistency county wide.

- The WET Internship programs continue to be one of the largest behavioral health internship programs in the Inland Empire. The Graduate Internship, Field, and Traineeship (GIFT) Program received over 120 applications and accepted 37 master or bachelor students into the program. Students were from 10 different universities. 42% of the students were multi-lingual with over 50% of being Spanish speakers. Many had lived experience (as a consumer or family member). Demographically, 51% identified as Hispanic or Hispanic mixed with another race, 21% Caucasian or white, 11% as African American, and 3 % identified as other races (Asian or Multiple Mixed Races).

***Capital Facilities and Technology (CFTN)***

- Mead Valley Wellness Village broke ground in 2024. Full service Behavioral Health Campus that serves as a safe, monitored, and therapeutic community and living space while simultaneously delivering high quality, person-first, treatment for Behavioral Health. The Village will be architecturally designed and landscaped and offer a full continuum of behavioral health care in one location. Consumers and their families move through the campus' continuum of care from intensive oversight and treatment activities, to decreased therapeutic contact enabling consumers to prepare for a self-sustained recovery grounded in their own community. The Village is schedule to open in December 2026.

- Renovation has completed on an augmented adult residential facility on Franklin Avenue in the City of Riverside. This adult residential facility provides 84 beds with integrated, onsite full-service partnership (FSP) services. This facility provides a level of service comparable to the department's existing adult residential and care facility location in Palm Springs (Roy's Desert Springs & Windy Springs Wellness Center combination).

***Regional Grid***

**Regional Key Program Grid MHSA Annual Update FY 25-26**

## Community Services & Supports (CSS): Full Service Partnership (FSP)

| | Western Region | Mid-County Region | Desert Region |
|---|---|---|---|
| FSP Track in outpatient clinics | X | X | X |
| FSP Outreach Prior to Acute Hospital Discharge | X | X | X |
| **Children's FSP** | | | |
| Multi Dimentinal Family Therapy | X | X | X |
| Wraparound | X | X | X |
| Youth Hospital Intervention Program (YHIP) | X | X | X |
| **TAY (Transitional Age Youth):** | | | |
| TAY FSP Program | X | X | X |
| **Adult:** | | | |
| Adult FSP Program | X | X | X |
| **Older Adult FSP:** | | | |
| SMART Program | X | X | X |

## CSS: General Service Development (GSD)

| | | | |
|---|---|---|---|
| **General** | | | |
| BH Care at Community Health Center | X | X | X |
| Parent Child Interaction Therapy/Preschool 0-5 | X | X | X |
| DBT, Eating Disorder, NCI, MI, TF-CBT, other EBP | X | X | X |
| TAY Centers | X | X | X |
| **Crisis System of Care:** | | | |
| 24/7 Mobile Crisis Teams | X | X | X |
| Mental Health Urgent Care (MHUC) | X | X | X |
| Crisis Residential Treatment (CRT) | X | X | X |
| Clinician/Police Partner Teams (CBAT) | X | X | X |
| **Mental Health Court & Justice Related:** | | | |
| Mental Health Court/Veterans Court | X | X | X |
| Homeless Court | X | | X |
| Law Enforcement Education Collaboration (CIT) | X | X | X |
| Youth Treatment Education Center | X | | |
| Juvenile Justice EBP | X | X | X |
| Adult Detention BH Discharge Preparedness | X | X | X |
| Laura's Law Assisted Outpatient Treatment | X | x | x |
| CARE Court (Includes mobile access countywide) | X | | |

## CSS: Outreach and Engagement

| | | | |
|---|---|---|---|
| **Lived Experience Programs:** | | | |
| *Consumer Affairs: Peer Support* | | | |
| Peer Support and Resource Centers | X | X | X |
| Peer Support Specialist Certification Classes | X | X | X |
| WRAP/Facing Up/WELL | X | X | X |
| *Parent Support & Training: Parent Partners* | | | |
| Educate, Equip & Support | X | X | X |
| Triple P/Triple P Teen | X | X | X |
| Nurturing Parenting | X | X | X |
| Parent Partner Training | X | X | X |
| *Family Advocates:* | | | |
| Family WRAP (English & Spanish) | X | X | X |
| Family to Family Classes (English & Spanish) | X | X | X |
| DBT for Family (English & Spanish) | X | X | X |

## *Regional Grid*

| | | | |
|---|---|---|---|
| **Housing & Housing Programs:** | | | |
| HHOPE Programs | X | X | X |
| Homeless Outreach Teams | X | X | X |
| Permanent Housing Property for Chronic Homelessness | X | | X |
| Permanent Supportive Housing Units | X | X | X |

### Prevention and Early Intervention (PEI)

| | Western Region | Mid-County Region | Desert Region |
|---|---|---|---|
| **Mental Health Outreach, Awareness & Stigma Reduction:** | | | |
| Stand Against Stigma (formerly Contact for Change) | X | X | X |
| Promotores de Salud Mental y Bienestar | X | X | X |
| Community Mental Health Promotion Program | X | X | X |
| Integrated Outreach & Screening | X | X | X |
| Asian/PI Mental Health Resource Center | X | X | |
| Helpline | X | X | X |
| **Parent Education & Support:** | | | |
| Triple P - Positive Parenting Program | X | X | X |
| Mobile MH Clinics & Preschool 0-5 Program | X | X | X |
| Strengthening Families | X | X | X |
| **Trasistion Age Youth (TAY) Project:** | | | |
| Stress and Your Mood | X | X | X |
| TAY Peer-to-Peer Services | X | X | X |
| Active Minds Chapters (Send Silence Packing) | X | X | X |
| Outreach to Runaway Youth/Safe Places | X | X | X |
| Teen Suicide Awareness & Prevention Program | X | X | X |
| **First Onset for Older Adults:** | | | |
| Cognitive Behavioral Therapy for Late-Life Depression | X | X | X |
| Program to Encourage Active Rewarding Lives (PEARLS) | X | X | X |
| Care Pathways - Caregiver Support Groups | X | X | X |
| Mental Health Liaisons to Office on Aging | X | | X |
| Carelink/Healthy IDEAS | X | X | X |
| **Trauma-Exposed Services:** | | | |
| Cognitive Behavioral Intervention for Trauma in Schools | X | X | X |
| Seeking Safety TAY | X | X | X |
| Seeking Safety Adult | X | X | X |
| **Underserved Cultural Populations:** | | | |
| Mamas y Bebes (Mothers & Babies) | X | X | X |
| Native American Project | X | X | X |
| Asian American Project/KITE | X | X | |

### Innovation (INN)

| | Western Region | Mid-County Region | Desert Region |
|---|---|---|---|
| **Tech-Suite (Help @ Hand) Project:** | X | X | X |
| **Mindful Body and Recovery Project** | X | (But serves county wide) | |

## *MHSA Community Planning and Local Review*

### Understanding the Stakeholder Process

Who Is a Stakeholder?

Stakeholders are people who have a vested interest in Public Behavioral Health care in Riverside County. A stakeholder can be anyone: a consumer or family member; a care or protection services professional; other private or public service agencies and officials; community-based organizations; community advocates; cultural community leaders; faith-based organizations; schools; neighbors; parents and parent organizations – anyone who cares about behavioral health and the programs developed to meet Riverside County's behavioral health needs and wellness.

Local Stakeholder Process

Mental Health Services Act operates under rules and regulations that were originally established by Proposition 63, the 2004 voter approval ballot measure that created the legislation. At the heart of that legislation is a regulation requiring a "community stakeholder process." Essentially, the people of Riverside County who have a vested interest in public behavioral health care need a guaranteed voice in the planning and review of MHSA programs.

Stakeholder feedback is sought and accepted all year round and can be provided in person, over the phone, in writing, or electronically. MHSA has its own page on the RUHS-BH website, where the MHSA Plan and feedback forms are available. All MHSA Administration employees are trained to seek, listen for, and recognize community feedback regardless of when or how they interact with a Riverside County stakeholder. They are directed to integrate that feedback into all related planning and advocacy

**Stakeholder Partner and Participation Directory**

# Introduction

***MHSA Stakeholder Partnership and Participation Structure:***
***"How Can My Voice Be Heard?"***

Riverside University HEALTH SYSTEM
Behavioral Health

| BHC & Community Advisory | Collaboratives | Forums | Posting and Public Hearing |
|---|---|---|---|
| **Behavioral Health Commission**<br>Commission Meetings<br>• Central<br>• Regional (Desert, Mid-County, Western) | **Prevention and Early Intervention**<br>• Steering Committee*<br>• Quarterly Collaborative Meetings (Sign up at PEI@ruhealth.org) | **Focus Groups**<br>Focus Groups are coordinated meetings designed to get specific feedback on community needs. They are sometimes used to initiate planning, sustain planning, or to concentrate feedback from a particular population or group. | **Plan Draft Distribution**<br>• RUHS-BH Clinics/Programs<br>• Residential Housing<br>• Peer Centers<br>• Public Libraries<br>• Requested by community organizations |
| **Behavioral Health Commission**<br>Standing Committees<br>• Adult System of Care<br>• Children's Committee<br>• Criminal Justice<br>• Housing<br>• Legislative<br>• Older Adult System of Care<br>• Veteran's Committee | **Workforce Education and Training**<br>• Steering Committee*<br>• Workforce survey, training evaluations, and feedback forms<br>• Academic and community pipeline committees | **MHSA Forums**<br>MHSA forums are an opportunity to learn and ask questions about MHSA-funded programs. | **Public Hearing**<br>Public Hearing provides the community an opportunity to give feedback on a proposed MHSA plan<br>• Typically scheduled in May for annual update<br>• Virtual and/or in-person<br>• Sometimes scheduled at other times of the year based on plan amendments |
| **Cultural Competency**<br>• Reducing Disparities<br>• African American<br>• Asian American<br>• LGBTQIA+<br>• Middle Eastern North African<br>• Deaf and Hard of Hearing<br>• People with Disabilities<br>• Spirituality and Interfaith<br>• Native American<br>• Hispanic-Latinx | | | https://bit.ly/3WePulf<br>**MHSA Tab**<br>• Most recent annual update and latest 3-Year plan<br>• Includes electronic feedback forms<br>• MHSA@ruhealth.org<br>• (951)955-7156 |

*Closed meeting

(Rev 01/2025)

Riverside University HEALTH SYSTEM Behavioral Health

## 2025 MEETING SCHEDULE

### BEHAVIORAL HEALTH COMMISSION & REGIONAL ADVISORY BOARD

**(Hybrid Option Available, Meetings and locations subject to change. For further information, please contact the assigned Committee Executive Assistant. Thank you)**

### BEHAVIORAL HEALTH COMMISSION

1st Wednesday of the month at 12:00 noon at the following location: Riverside University Health System – Behavioral Health, 2085 Rustin Avenue, Riverside, CA 92507- Entrance 1, Conference Room 1051

| | | | |
|---|---|---|---|
| January 9, 2025 | February 5, 2025 | March 5, 2025 | April 2, 2025 |
| May 7, 2025 | June 4, 2025 | July 2, 2025 | August – DARK |
| September 3, 2025 | October 1, 2025 | November 5, 2025 | December - DARK |

*For further information, please contact Sylvia Bishop at (951) 955-7141.*

### DESERT REGIONAL BOARD

2nd Tuesday of the month at 12:00 noon at the following location: Indio Mental Health Clinic, 47-825 Oasis Street, Indio, CA 92201

| | | | |
|---|---|---|---|
| January 14, 2025 | February 11, 2025 | March 11, 2025 | April 8, 2025 |
| May 13, 2025 | June 10, 2025 | July 8, 2025 | August – DARK |
| September 9, 2025 | October 14, 2025 | November 11, 2025 | December - DARK |

*For further information, please contact Mary Carpio at (760) 863-8586.*

### MID-COUNTY REGIONAL BOARD

1st Thursday of the month at 3:00 p.m. at varying locations within the Mid-County Region

| | | | |
|---|---|---|---|
| January 2, 2025 | February 6, 2025 | March 6, 2025 | April 3, 2025 |
| May 1, 2025 | June 5, 2025 | July 10, 2025 | August – DARK |
| September 4, 2025 | October 2, 2025 | November 6, 2025 | December – DARK |

*For further information and to confirm location, please contact Hilda Gallegos at (951) 943-8015 or Elizabeth Lagunas at (951) 940-6215.*

### WESTERN REGIONAL BOARD

1st Wednesday of the month at 3:00 p.m. at 2085 Rustin Avenue, Riverside, CA 92507- Entrance 1

| | | | |
|---|---|---|---|
| January 9, 2025 | February 5, 2025 | March 5, 2025 | April 2, 2025 |
| May 7, 2025 | June 4, 2025 | July 2, 2025 | August – DARK |
| September 3, 2025 | October 1, 2025 | November 5, 2025 | December - DARK |

*For further information, please contact Jocelyn Aleman at (951) 358-8335.*

2025 Meeting Schedule

# Introduction

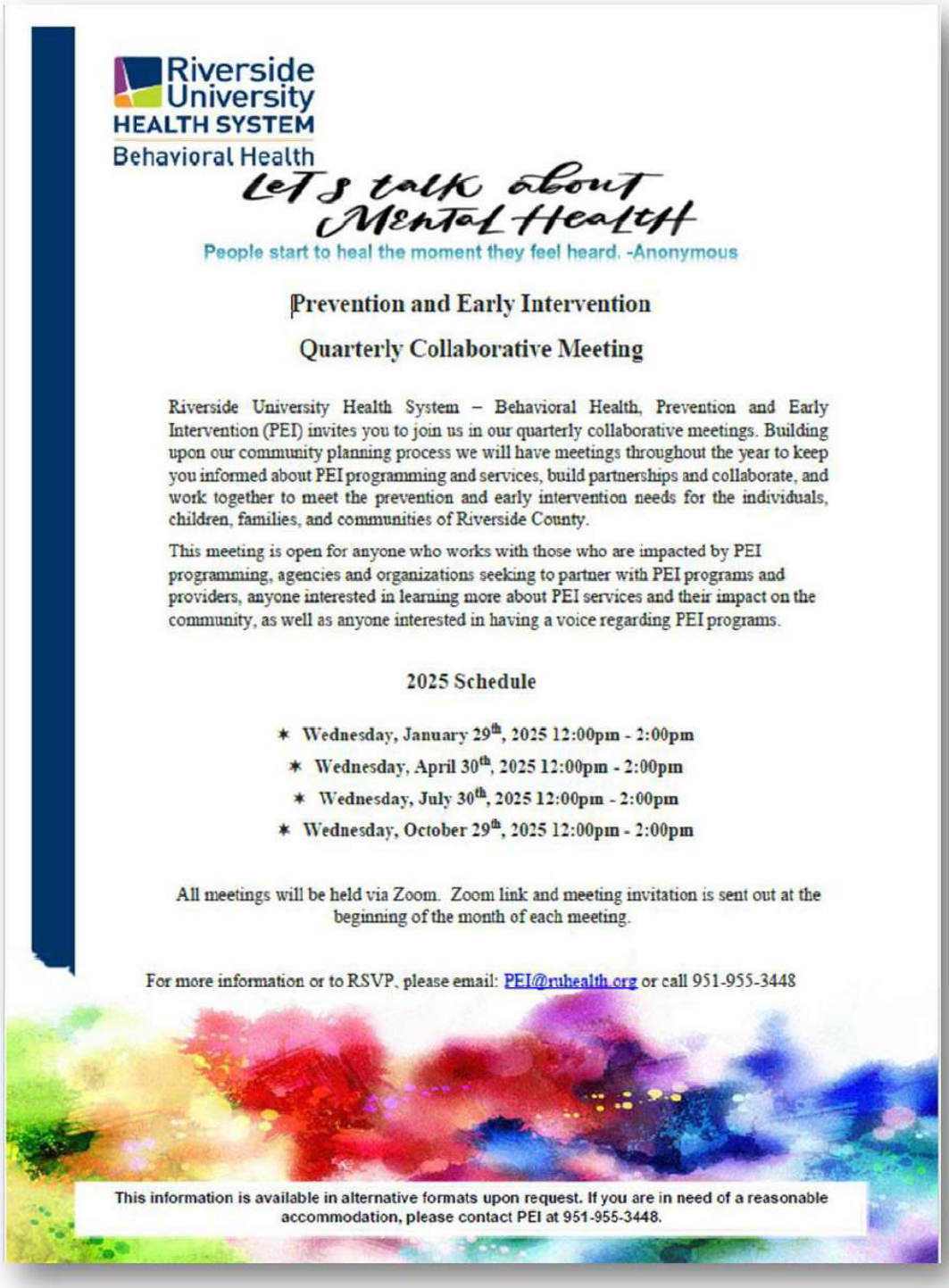
Riverside University HEALTH SYSTEM
Behavioral Health

**BEHAVIORAL HEALTH COMMISSION - STANDING COMMITTEES 2025 MEETING SCHEDULE**

(Hybrid Option Available, Meetings and locations are subject to change. For further information, please contact the assigned Executive Assistant. Thank you)

| ADULT SYSTEM OF CARE COMMITTEE | CHILDREN'S COMMITTEE | CRIMINAL JUSTICE COMMITTEE | HOUSING COMMITTEE | LEGISLATIVE COMMITTEE | OLDER ADULT INTEGRATED SYSTEM OF CARE COMMITTEE | VETERAN'S COMMITTEE |
|---|---|---|---|---|---|---|
| *Last Thursday @ 12pm* ***(Meeting location rotated between Riverside & Perris)*** | *4th Tuesday @ 12:00pm 2085 Rustin Avenue Riverside, CA 92507* | *2nd Wednesday @ 12pm 3625 14th Street Riverside, CA 92501* | *2nd Tuesday @ 11 am 2085 Rustin Avenue Riverside, CA 92507* | *1st Wednesday @ 10:30 am 2085 Rustin Avenue Riverside, CA 92507* | *2nd Tuesday @ 12pm 2085 Rustin Avenue Riverside, CA 92507* ***(Location differs in Feb. & Nov.)*** | *1st Wednesday @ 10:00 am 2085 Rustin Avenue Riverside, CA 92507* |
| January 30, 2025 | January 28, 2025 | January 15, 2025 | January 14, 2025 | N/A | January 14, 2025 | January 9, 2025 |
| February 27, 2025 | February 25, 2025 | N/A | February 11, 2025 | February 5, 2025 | February 11, 2025 | N/A |
| March 27, 2025 | March 25, 2025 | March 19, 2025 | March 11, 2025 | N/A | March 11, 2025 | March 5, 2025 |
| April 24, 2025 | April 22, 2025 | N/A | April 8, 2025 | April 2, 2025 | April 8, 2025 | N/A |
| May 29, 2025 | May 27, 2025 | May 21, 2025 | May 13, 2025 | N/A | May 13, 2025 | May 7, 2025 |
| June 26, 2025 | June 24, 2025 | N/A | June 10, 2025 | June 4, 2025 | June 10, 2025 | N/A |
| July 31, 2025 | July 22, 2025 | July 16, 2025 | July 8, 2025 | N/A | July 8, 2025 | July 2, 2025 |
| August – DARK | August – DARK | N/A | August – DARK | August – DARK | August – DARK | N/A |
| September 25, 2025 | September 23, 2025 | September 17, 2025 | September 9, 2025 | N/A | September 9, 2025 | September 3, 2025 |
| October 30, 2025 | October 28, 2025 | N/A | October 14, 2025 | October 1, 2025 | October 14, 2025 | N/A |
| November 20, 2025 | N/A | November 19, 2025 | November 11, 2025 | N/A | **TBA** | November 5, 2025 |
| December – DARK | December 9, 2025 | N/A | December - DARK | December – DARK | December – DARK | N/A |
| **Committee Executive Assistant Elizabeth Lagunas (951) 940-6215** | **Committee Executive Assistant Saida Spencer (951) 358-7348** | **Committee Executive Assistant Dinah Navarro (951) 955-1530** | **Committee Executive Assistant Rachel Zapata (951) 210-1459** | **Committee Executive Assistant Sandy Awad (951) 955-7156** | **Committee Executive Assistant Cynthia Peterson (951) 358-5891** | **Committee Executive Assistant Miriam Resendiz (951) 955-7138** |

2025 Meeting Schedule



Riverside University HEALTH SYSTEM Behavioral Health

Let's talk about Mental Health

People start to heal the moment they feel heard. -Anonymous

**Prevention and Early Intervention**

**Quarterly Collaborative Meeting**

Riverside University Health System – Behavioral Health, Prevention and Early Intervention (PEI) invites you to join us in our quarterly collaborative meetings. Building upon our community planning process we will have meetings throughout the year to keep you informed about PEI programming and services, build partnerships and collaborate, and work together to meet the prevention and early intervention needs for the individuals, children, families, and communities of Riverside County.

This meeting is open for anyone who works with those who are impacted by PEI programming, agencies and organizations seeking to partner with PEI programs and providers, anyone interested in learning more about PEI services and their impact on the community, as well as anyone interested in having a voice regarding PEI programs.

**2025 Schedule**

- **Wednesday, January 29th, 2025 12:00pm - 2:00pm**
- **Wednesday, April 30th, 2025 12:00pm - 2:00pm**
- **Wednesday, July 30th, 2025 12:00pm - 2:00pm**
- **Wednesday, October 29th, 2025 12:00pm - 2:00pm**

All meetings will be held via Zoom. Zoom link and meeting invitation is sent out at the beginning of the month of each meeting.

For more information or to RSVP, please email: PEI@ruhealth.org or call 951-955-3448

This information is available in alternative formats upon request. If you are in need of a reasonable accommodation, please contact PEI at 951-955-3448.

TAY ARENA COLLAB
2025
JOIN US FOR A MONTHLY MEETING OF COMMUNITY PARTNERS, TRANSITIONAL AGE YOUTH (TAY), AND RIVERSIDE COUNTY PROGRAMS TO ADDRESS THE NEEDS OF TAY IN MID-COUNTY.
✨ NETWORK | COLLABORATE | DISCUSS
MEETINGS ARE THE 4TH WEDNESDAY OF EVERY MONTH FROM 3-4:30 PM
LOCATED AT:
THE TAY ARENA
2560 N. PERRIS BLVD, STE. N-1, PERRIS
AND
VIRTUALLY ON MS TEAMS
(EMAIL: LAADAMSON@RUHEALTH.ORG FOR INVITE)
JANUARY 22, 2025
FEBRUARY 26, 2025
MARCH 26, 2025
APRIL 23, 2025
MAY 28, 2025
JUNE 25, 2025
JULY 23, 2025
AUGUST 27, 2025
SEPTEMBER 24, 2025
OCTOBER 22, 2025
NOVEMBER 26, 2025
DECEMBER IS DARK (NO MEETING)

**RUHS Desert COLLABORATIVE - 2025**

**DATE:** Wednesday, January 8, 2025 / 2:00 – 3:30 PM
**Building:** IN0735
**Room:** Rooms 402/402A

**Task Description: RUHS Desert Collaborative** 2:00pm – 3:30pm
Contact: Ashley Jean w/ RUHS Behavioral Health phone # 760-863-7067

**Guest Presenter: Honor Moore – 417 Recovery**

**DATE:** Tuesday, February 4, 2025 / 2:00 – 3:30 PM
**Building:** IN0735
**Room:** Rooms 402/402A

**Task Description: RUHS Desert Collaborative** 2:00pm – 3:30pm
Contact: Ashley Jean w/ RUHS Behavioral Health phone # 760-863-7067

**Guest Presenter: Erika Edney & James Gaylor – First Episode Psychosis**

**DATE:** Wednesday, March 5, 2025 / 2:00 – 3:30 PM
**Building:** IN0735
**Room:** Rooms 402/402A

**Task Description: RUHS Desert Collaborative** 2:00pm – 3:30pm
Contact: Ashley Jean w/ RUHS Behavioral Health phone # 760-863-7067

**Guest Presenter: Julie Hirsh – Jewish Family Services**

**DATE:** Wednesday, April 2, 2025 / 2:00 – 3:30 PM
**Building:** IN0735
**Room:** Rooms 402/402A

**Task Description: RUHS Desert Collaborative** 2:00pm – 3:30pm
Contact: Ashley Jean w/ RUHS Behavioral Health phone # 760-863-7067

**Guest Presenter: Michelle Salado – Alzheimer's Association**

**DATE:** Wednesday, May 7, 2025 / 2:00 – 3:30 PM
**Building:** IN0735
**Room:** Rooms 402/402A

**Task Description: RUHS Desert Collaborative** 2:00pm – 3:30pm
Contact: Ashley Jean w/ RUHS Behavioral Health phone # 760-863-7067

**Guest Presenter: Bryan Kneiding- California Family Life Center**

**DATE:** Wednesday, June 4, 2025 / 2:00 – 3:30 PM
**Building:** IN0735
**Room:** Rooms 402/402A

**Task Description: RUHS Desert Collaborative** 2:00pm – 3:30pm
Contact: Ashley Jean w/ RUHS Behavioral Health phone # 760-863-7067

**Guest Presenter: Melissa Vasquez - Take My Hand**

**DATE:** Wednesday, July 2, 2025 / 2:00 – 3:30 PM
**Building:** IN0735
**Room:** Rooms 402/402A

**Task Description: RUHS Desert Collaborative** 2:00pm – 3:30pm
Contact: Ashley Jean w/ RUHS Behavioral Health phone # 760-863-7067

**Guest Presenter: Renae Punzalan - LGBTQ+ Youth Drop-In center**

**DATE:** Wednesday, August 6, 2025 / 2:00 – 3:30 PM
**Building:** IN0735
**Room:** Rooms 402/402A

**Task Description: RUHS Desert Collaborative** 2:00pm – 3:30pm
Contact: Ashley Jean w/ RUHS Behavioral Health phone # 760-863-7067

**Guest Presenter:**

*ALL dates confirmed w/Amber Norman

# Cultural Competency MEETINGS

**AAFWAG**
African American Family Wellness Advisory Group
**10:00 a.m. to 11:30 a.m.**
*Meets on the 3rd Wednesday of every month.*

**APIDANH**
Asian, Pacific Islander, Desi American, & Native Hawaiian
**3:30 p.m. to 5:00 p.m.**
*Meets Bi-monthly on the 2nd Tuesday.*

**CAGSI**
Community Advocating for Gender and Sexuality Inclusion
**2:30 p.m. to 4:00 p.m.**
*Meets Bi-monthly on the 3rd Tuesday.*

**CCRD**
Cultural Competency Reducing Disparities Committee
**9:00 a.m. to 11:00 a.m.**
*Meets on the 2nd Wednesday of every month.*

**DCAN**
Deaf Collaborative Advisory Network
**4:00 p.m. to 6:00 p.m.**
*Meets Bi-monthly, rotating virtually on Mondays and in-person on Saturdays.*

**HISLA**
Hispanic, Latinx
**3:00 p.m. to 5:00 p.m.**
*Meets the last Thursday of every month.*

**MECCA/MENA**
MECCA/Middle Eastern & North African
**2:30 p.m. to 3:30 p.m.**
*Meets Bi-monthly on the 3rd Wednesday.*

**NATIVE AMERICAN**
Native American Wellness Advisory
**3:30 p.m. to 5:00 p.m.**
*Meets on the 3rd Monday of every month.*

**WADE**
Wellness & Disability Equity Alliance
**1:00 p.m. to 2:30 p.m.**
*Meets on the 1st Friday of every month.*

**SPIRITUALITY and FAITH-BASED**
Interfaith and Spirituality
**10:00 a.m. to 11:30 a.m.**
*Meets on the 2nd Tuesday of every month.*

*f_;et's break the stioma.*

# CCRD

CliilTURAL **COMPETENCY REDUCINGDISPARITIESCOMMITTEE**

CCRD is a coalition of community leaders representing the diverse cultural groups l Riverside.

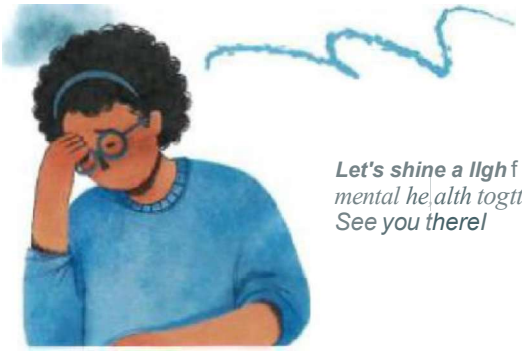
They are united in a shared strategy to effectlvely address the behavioral health care needs of tradltionally underse ved communit es. The CCRO stands by the following values:

- Inclusion
- **Respect**
- Community Callab oratlon
  Access
  **Safety**

:· **Date:** Meets on the 2nd Wednesday of

! every monl•
**Time:** '9 - 11am
**Loe tion:** Virtual

**Regl ter:** tps://blt.ly/RUHS-CCRD



***Let's shine a llgh*** f *on mental he alth togtthtr. See you therel*

R"verside Universitv
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MHSA Administration collaborates with existing community advisory and oversight groups. MHSA Administration employees attend these committees, and the committees were included in the MHSA 3-year planning and annual update process. These committees often advocate for the needs of a particular at-risk population or advocate for the needs of the underserved. The following are the groups that serve as key advisors in Riverside's stakeholder process:

- **Riverside County Behavioral Health Commission (BHC) and Regional Mental Health Boards**: The BHC acts as a community focal point for behavioral health issues by reviewing & evaluating the community's mental health needs, services, facilities, & special problems. Members are appointed by the Riverside County Board of Supervisors (BOS) and represent each of the Supervisorial Districts. Each region of Riverside County (Western, Mid-County, Desert) has a local Mental Health Board that serves in a similar capacity and helps to inform the greater BHC. The BHC advises the Board of Supervisors & the Behavioral Health Director regarding any aspect of local behavioral health programs. BHC meetings are held monthly and are open to the community.

  - The BHC also hosts subcommittees designed to seek community feedback and recommendations on specific service populations or higher-risk communities. These committees meet monthly and are open to the community and welcome community participation. A member of the BHC chairs the subcommittees. MHSA Administration relies on these subcommittees to advise on program areas related to the committees' special attention:
    - Adult System of Care
    - Children's System of Care (includes Children, Parents/Families, and TAY)
    - Older Adult System of Care (includes caregivers)
    - Criminal Justice (includes justice-involved consumers, and the need of law enforcement to intervene with consumers in the justice system)
    - Housing (addresses homelessness and housing development)
    - Legislative Committee (examines BH related legislation)
    - Veteran's Committee (includes the behavioral health needs of US Veterans and their families)

- **RUHS Cultural Competency Program:** The Cultural Competency Program provides overall direction, focus, and organization in implementing the system-wide Cultural Competency Plan aimed at enhancing service delivery and workforce development. The plan concentrates on integrating the languages, cultures, beliefs, and practices of consumers into Behavioral Health Care service delivery. Cultural Competency encompasses underserved ethnic populations, the LGBTQ community, the Deaf and Hard of Hearing, the physically disabled communities, and faith-based communities.

  - Cultural Community Liaisons: Contracted ethnic and cultural leaders that represent identified underserved populations within Riverside County. Liaisons provide linkage to those identified populations. The primary goals of the consultant are:

(1) to create a welcoming and transparent partnership with community-based organizations and community representatives to eliminate barriers to service.

(2) to educate and inform the community about behavioral health and behavioral health services to reduce disparity in access to services, recovery, and wellness.

- Cultural Populations Advisory Groups: The Cultural Community Liaisons chair or co-chair a related committee that is respective of each of the underserved communities they represent. The advisory groups counsel RUHS-BH on culturally informed engagement and service delivery. These advisory groups meet on a regular schedule and welcome community participation:

- Community Advocacy for Gender and Sexuality Inclusion and Equity (CAGSIE)
- African American Family Wellness Advisory Group (AAFWAG)
- Asian, Pacific Islander, Desi American, & Native Hawaiian (APIDANH)
- Hispanic-LatinX (HISLA)
- Middle Eastern North African (MENA)
- Deaf Collaborative Advisory Network (DCAN)
- Wellness & Disability Equity Alliance (WADE)
- Spirituality and Faith-Based
- Native American Wellness Advisory (NAWA)
- RUHS-BH has an existing Veteran's Services Liaison who was reorganized under Cultural Competency and attends the Veteran's Committee under the Behavioral Health Commission

- Cultural Competency Reducing Disparities Committee (CCRD): A collaboration among community leaders representing Riverside's diverse cultural communities, united in a collective strategy to better address the behavioral health care needs of traditionally underserved populations. CCRD is chaired by a mental health professional from the Cultural Competency Program and is overseen by the RUHS-BH Cultural Competency Manager. CCRD meets monthly and is open to the public.

- **RUHS-BH Lived Experience Programs**: RUHS-BH is recognized for its peer programming. We have programs based on lived experience across various care populations: consumer peer, family member, and parent. Each program is led by a Peer Planning and Policy Specialist, a department manager with corresponding lived experience. As part of our developing peer management, we hired a Deputy Director of Peer Support Services, who has lived experience in all three areas, and the managerial positions now report to her. Not only are peer staff integrated into clinic programs throughout Riverside County, but they also coordinate and engage in outreach activities to help educate others about recovery, reduce stigma, and support wellness. They play an essential role in our planning process, not only from their peer perspective but also due to their daily involvement in the community with individuals affected by behavioral health challenges.

- **Steering Committees, Collaboratives, and Community Consortiums:** Members of Steering Committees are subject matter experts or community representatives who are dedicated to expanding their knowledge of a MHSA component to provide an informed perspective during plan development. Collaboratives are regularly scheduled mini-conferences where stakeholders of MHSA components gather to hear about regulatory updates and share progress reports. Community Consortiums are meetings hosted by community or partner agencies that convene similar stakeholders to collaboratively address, plan for, and meet community needs. The MHSA Administration coordinates steering committees for Workforce Education and Training (WET) and Prevention and Early Intervention (PEI), and hosts a PEI Collaborative. Staff from MHSA administration also participate in the RUHS-BH TAY Collaborative and consortiums that include members from academic institutions, community-based organizations, sister county MHSA programs, school districts, public health and allied county departments, and justice-involved agencies.

### MHSA Annual Plan Update Stakeholder Education and Feedback

Representatives from MHSA Administration provide annual MHSA education and plan updates to our network of community advisory groups at the beginning of the calendar year. The representative used a PowerPoint curriculum that is part of the "MHSA Toolkit" also attached to the email announcing the community participation process. The PowerPoint curriculum can also be found on the MHSA Annual Update landing page of the Department's website. A copy of the PowerPoint is included in the introduction of this document under "MHSA Quick Look." In addition, MHSA regularly attends or has a standing point on the agenda for feedback, education, and program updates at the following meetings:[2]

- Behavioral Health Commission
- Cultural Competency Reducing Disparities Asian American Task Force
- African American Family Wellness Advisory Group Community Advisory on Gender and Sexuality Issues, Hispanic-Latinx Advisory Group
- Middle Eastern North African Advisory Group Deaf and Hard of Hearing Advisory Group Wellness and Disability Equity Alliance
- Native American Advisory Group
- Spirituality and Faith-Based Advisory Group
- Children's System of Care
- Adult System of Care Older Adult System of Care
- Transitional Age Youth Collaborative Veterans' Committee

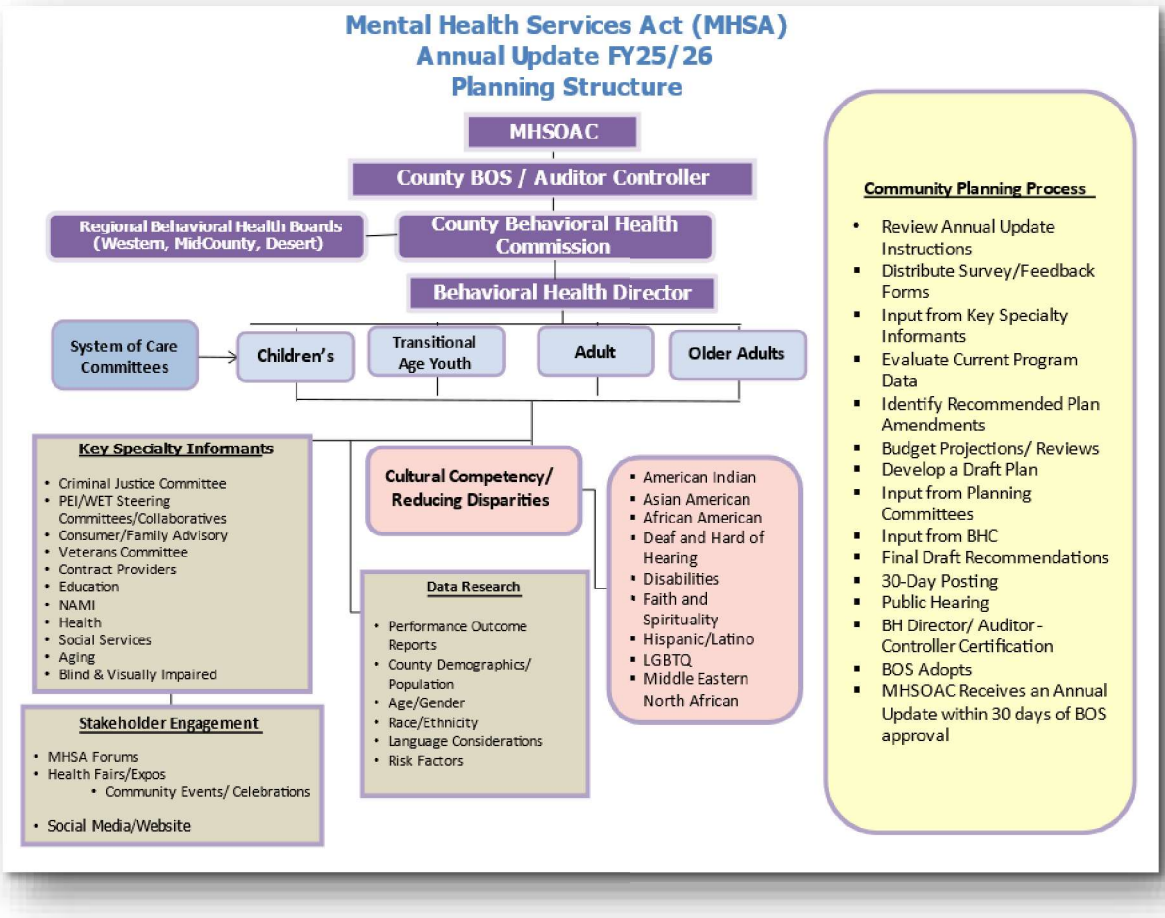
[2] Meeting dates and time are included in this Introduction under the Stakeholder Partner and Participation Directory

***All meetings took place in 2025***[3]

| | |
|---|---|
| Deaf and Hard of Hearing | 1/27/2025 |
| Prevention and Early Intervention Collaborative | 1/29/2025 |
| Western Regional Mental Health Board | 2/5/2025 |
| Legislative Committee | 2/5& 6/3,2025 |
| Behavioral Health Commission | 2/5/2025 |
| Desert Regional Mental Health Board | 2/11/2025 |
| Children's Coordinators | 2/11/2025 |
| Children's Providers | 2/13/2025 |
| Transitional Age Youth Desert Collaborative | 3/4/2025 |
| Veteran's Committee | 3/5/2025 |
| RUHS-BH Manager's Meeting | 3/10/2025 |
| Housing Committee | 3/11/2025 |
| Older Adult System of Care | 3/11/2025 |
| Asian American Task Force | 3/11/2025 |
| Cultural Competency Reducing Disparities | 3/12/2025 |
| Transitional Age Youth Western Collaborative | 3/13/2025 |
| Community Advocating for Gender and Sexuality Issues | 3/18/2025 |
| Middle Eastern North African Advisory Group | 3/19/2025 |
| African American Family Wellness Advisory Group | 3/19/2025 |
| Children's Committee | 3/25/2025 |
| Transitional Age Youth Mid-County Collaborative | 3/26/2025 |
| Adult System of Care | 3/27/2025 |
| Behavioral Health Collective | 3/31/2025 |
| Mid-County Regional Board | 4/3/2025 |
| Wellness & Disability Equity Alliance | 4/4/2025 |
| Spirituality And Faith-Based Advisory Group | 4/8/2025 |
| Western Regional Collaborative | 4/14/2025 |
| Native American Advisory Group | 4/21/2025 |
| Hispanic Latinx | 4/24/2025 |
| Healthcare Discussion with Veterans | 4/27/2025 |
| Family Advocate Program | 4/30/2025 |
| Criminal Justice Committee | 5/14/2025 |

[3] All meetings can be found in the Stakeholder packet

**MHSA Annual Update Planning Structure**




## 30-Day Public Comment

The Draft MHSA Annual Update FY 25/26 was posted for a 30-day public review and comment period from April 1, 2025, to May 30. 2025.

## Public Hearing

MHSA regulations require that Riverside County post our draft plan for a 30-day public review and comment period, followed by a Public Hearing conducted by the Riverside County Behavioral Health Commission. This process typically begins months before and involves coordinating plan updates with RUHS-BH program managers, the Riverside County Behavioral Health Commission, our research department, program support, and fiscal units, as well as meeting with the stakeholder groups that comprise our primary advisory voices.

A public hearing was planned for the MHSA Annual Update FY 25/26 in an in-person format as follows:

**Virtual Format: "Public Hearing in your Pocket"**

1. Announce the 30-day Public Posting Period via repeated email distribution, our Department Webpage, and our social media accounts: X, Facebook, and Instagram. Announcements were provided in English and Spanish, including a link to the whole plan and an electronic feedback form. Videos are accessible 24 hours a day, seven days a week.

2. Attached to the email is a Riverside County "MHSA Toolkit," quick reference documents requested by our stakeholders that summarize plan changes, highlights, and goals. The kit also includes a grid organizing the service components by region, an orientation to MHSA, and a Stakeholder Directory to inform the community about year-round meetings where they can participate.

3. After the 30-day review period, a video presentation ("Public Hearing in Your Pocket") of the MHSA Plan overview, like the introduction of a standard public hearing, was posted daily on the RUHS-BH website from May 01 to May 25 and included a link to the whole plan, the electronic feedback form, and a voice mail telephone number. The presentation was conducted in both English and Spanish. The English and Spanish videos included an interpretation of American Sign Language.

4. DVDs of the presentation were also available for mail or pickup. They included a copy of the MHSA Toolkit and a stamped envelope to mail completed feedback forms. The DVDs can be closed-captioned in various languages.

**In-Person Public Hearing**

In-person, public hearings were planned to coincide with our popular community engagement festivals during May, which is Mental Health Month. They were scheduled in each county region as follows:

- Desert Region, May 1st, 2025
- Mid-County Region, May 8th, 2025
- Western Region, May 15th, 2025

MHSA Forums preceded Public Hearings. Forums were designed in "science fair" layouts, with each MHSA component represented at an education station hosted by related MHSA administration staff. Community members could move among the stations to learn more about MHSA, the plan, and the related programs/services, seek information, and discuss initial thoughts or ideas.

At the close of the forum, the formal public hearing began, conducted by a member of the Riverside County Behavioral Health Commission (BHC). The plan was reviewed visually, and public comments were initiated.

**Public Comment Documentation and Responses**

All comments received virtually and in person were compiled and reviewed by the BHC for a response. Comments and responses were added to this plan as a chapter in this document.

**Results of Virtual Public Hearing Process**

A total of 530,142 (in Spanish and English) saw the MHSA Annual Update FY 25/26 Public hearings promoted on Facebook, Instagram, YouTube, and Next-Door news feeds, Countywide. People engaged with the posts over 25 days, and the increase in impressions from Calendar year 24/25 was over 500%.

**Results of the In-Person Public Hearing Process**

In-person public Hearings were held in the three service delivery regions: Western, Mid-County, and Desert. A marketing campaign was created to advertise participation. It included a press release sent to all major local media, social media, website postings, announcements

sent on MHSA-related email distribution lists, and email notifications to all department employees with encouragement to share with clients and families. A total of 113 people attended the in-person forum, where the community could engage with the MHSA Administration Team and learn more about each of the five components of the plan. Behavioral Health Services Act and program access information were also available.

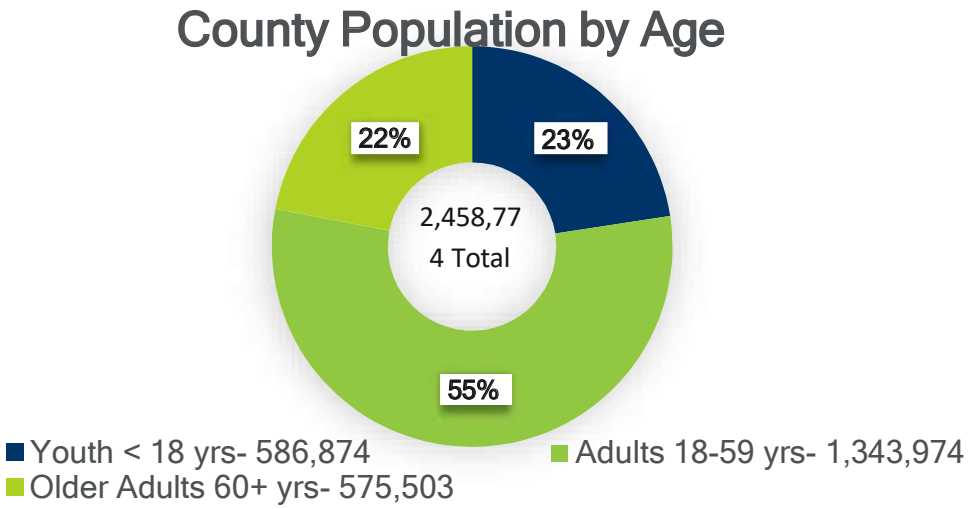
An Ad Hoc Committee of the Behavioral Health Commission met on June 16th, 2025, reviewed all public comments, and developed responses. Those comments and responses serve as a chapter in this annual update. The Behavioral Health Commission approved the final plan on July 02, 2025.

# MHSA Capacity Assessment

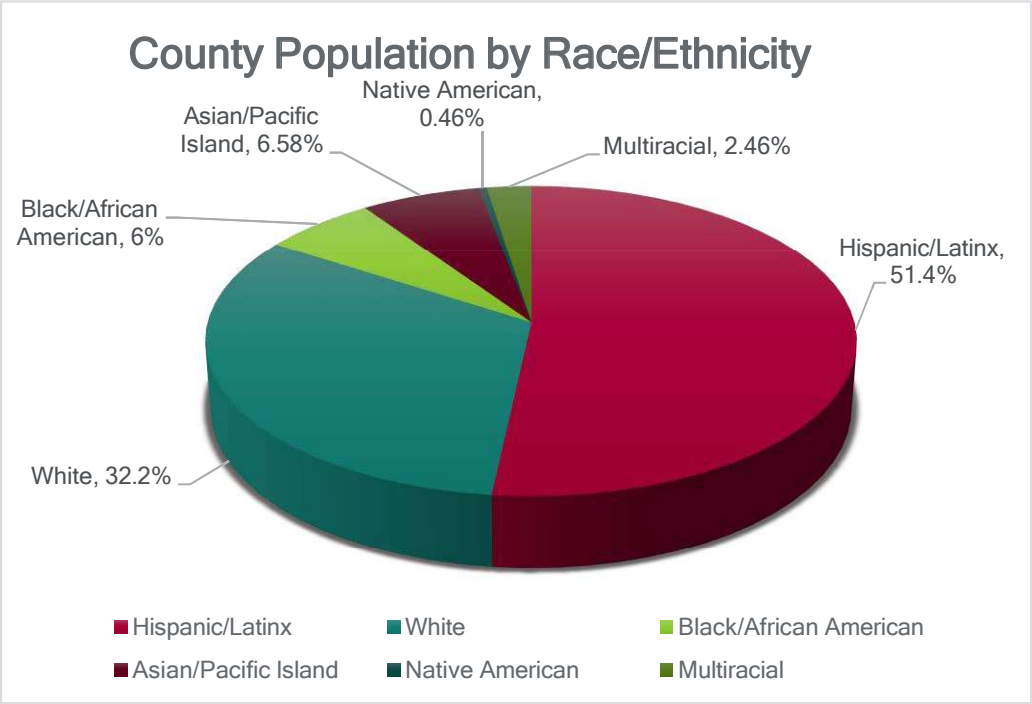
**Riverside County Population**

Riverside County is the fourth most populous County in California and the 10th most populous county in the United States. The County at 7,208 square miles spans nearly the width of California with service areas in the metropolitan western portion of the county to the rural community of Blythe at the Arizona border.

The County population has grown each year from 2010 to 2023. Youth under the age of 18 comprise nearly a quarter of the population (23.4%). Older Adults are almost a quarter of the population (22.9%). The Older Adult population has been increasing and the youth under age 18 has been decreasing over the last 5-10 years. Transition Age Youth (TAY), aged 16-25, represent 14.6% of the population, totaling 360,846 youth.



Riverside County has two large Race/Ethnic groups representing 83.6% of the population, Hispanic/Latinx and White. The Hispanic/Latinx group is the largest group in Riverside County. Asian/Pacific Islander groups have grown over time from 4% to 6.5% of the population currently. Black/African American has remained steady at 6% of the population. A number of tribes are spread throughout Riverside County with Native Americans representing less than 1% of the population.




Spanish is the only threshold language in Riverside County. More than a third of the County population 34.98% reported speaking Spanish and of these Spanish speakers 34% reported they speak English less than “very well”.

The California Health Interview Survey (CHIS) data was used to report the population identifying as Lesbian, Gay or Bisexual (LGB). Pooling the last 3 years of available data showed 7% of the adult population reported they identified as LGB. CHIS data was also used to identify the adult Transgender or gender Non-Conforming population, slightly more than one half of one percent (0.6%) of adults reported they identified as Transgender or Gender Non-Conforming. CHIS data among Teens surveyed showed 4.1% reported they identified as Transgender or Gender Non-Conforming.

Economic status for people living in Riverside County derived from the U.S Census showed 11.1% of the population (266,955) is living below the federal poverty level. The federal poverty level is $30,000 or less per year for a household of four people and $14,580 for a single person household. Living below the poverty level is higher for youth under the age of 18 at 14.1%. Additionally, 17% of the population (419,756) has income that is 200% above the poverty level, which qualifies many for social safety net benefits. The population at 200% and those living below the poverty line represent 28.4% of the County population. The median household income for

Riverside County, for those working full-time year-round, reported in U.S. Census data for 2023 was $75,340 in 2022, which means one-half the population is below $75,340 and one-half the population is at $75,340 or above. Census data on earnings for the last year for those working year-round full time (175,310 people) showed 22.4% (175,310) of those working full time earned $34,999 or less per year.

The Department of Health Care Services (DHCS) data on Medi-Cal eligibility for the most recent month showed the County has nearly 1 million Medi-Cal recipients (995,532). The Medi-Cal beneficiaries 42% of the overall County population. Children and youth age 0-18 represented 38% of the Medi-Cal eligible population, while adults accounted for 55% and older adults 65+ were 7% of the Medi-Cal population.

The 2023 Point in Time Homeless Count for Riverside County indicated 3,725 homeless people both sheltered and unsheltered; 65% (2,441) were unsheltered and 35% (1,284) were sheltered. The 2023 count was an overall increase of 12% from the previous year. However, most of that increases was in the homeless unsheltered population. Homeless families with children with children increased 12% (143) from the previous year. Riverside and Indio were the two cities with the highest homeless count. The Desert region in District 4 had the highest total number of homeless persons. The top three primary factors reported as contributing to unsheltered homelessness were Family disruption, lack of income, and unemployment. A Point in Time Count was not conducted in 2024, the results of the 2025 count were not yet available to include the results in this MHSA Annual update.

**Identifying Underserved and Unserved Populations**

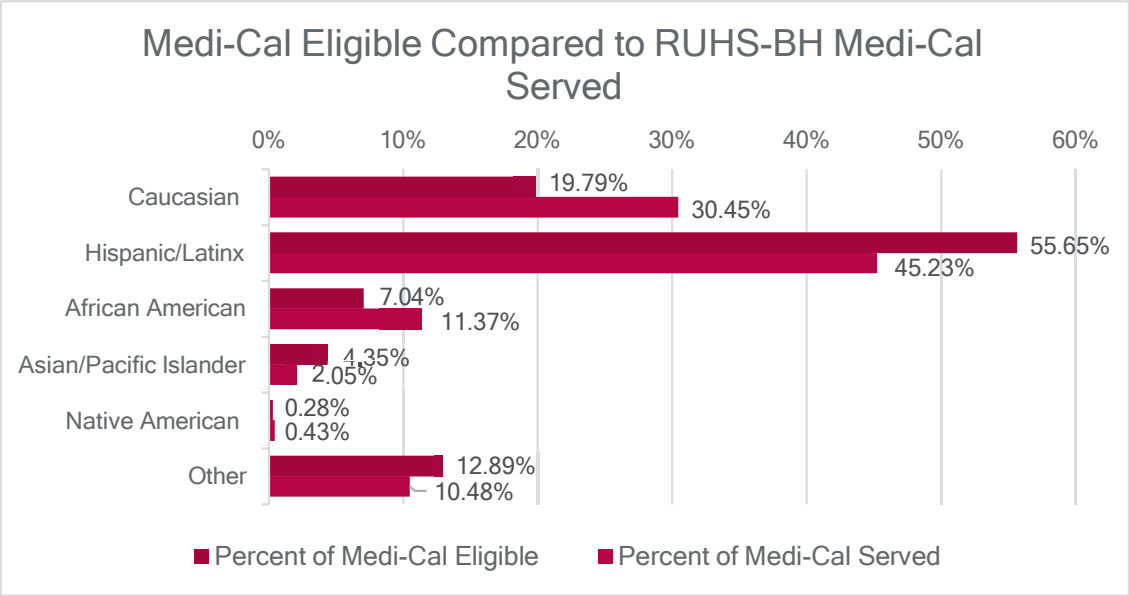
*Unmet need* is an estimate of how many mentally ill individuals there are in the county who may not be receiving the mental health services they need. Unmet need is calculated based on the difference between 1) known prevalence rates of mental illness and 2). How many consumers receive mental health services. RUHS-BH completed a detailed analysis of Unmet Need when drafting the initial MHSA proposal in 2003-2004; and has examined changes using the initial benchmarks. Since the implementation of MHSA, RUHS-BH has served 52% more consumers. Services to Youth under the age of 18 has increased by 30%, and services to adults has increased by 52%. Services to Older Adults have increased dramatically by 195%. Decreases in unmet need have been found for all age groups.

Disparities can be identified by utilizing Medi-Cal penetration rates. This is calculated as the proportion of Medi-Cal consumers served out of the total number of people with Medi-Cal eligibility. The California Department of Health Care Services uses Medi-Cal paid claims to provide penetration rates for each county. Data on penetration rate by age groups is shown in the following table.

| | County Rate | Large Counties | Statewide Rate |
|---|---|---|---|
| Youth <18 | 5.64% | 7.86% | 9.11% |
| Adults 18-59 | 4.71% | 4.72% | 5.06% |
| Older Adults 60+ | 2.92% | 2.56% | 2.92% |

Penetration rates for Adults and Older Adults are similar to other large counties and the statewide rates. Youth rates are lower than other large counties and the statewide rate, despite steady increases in the number of youth served this age group is somewhat underserved. Overall Medi-Cal penetration rates are impacted by the increases in Medi-Cal beneficiaries.

Comparisons between Medi-Cal population of beneficiaries to mental health clients served provides useful information on disparities. The following figure below shows Medi-Cal Eligible Compared to RUHS-BH Medi-Cal Served.

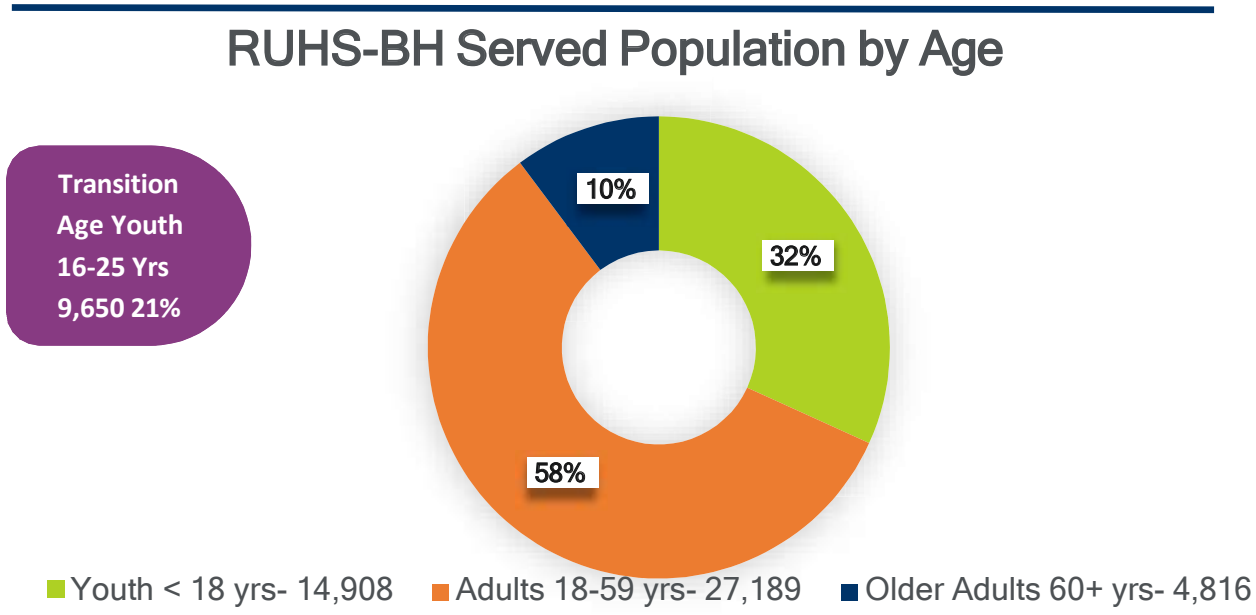



- The proportion of Caucasians served was nearly 1.5 times the respective Medi-Cal eligible proportion.
- Hispanic/Latinx represented over half of the county Medi-Cal eligible population, but their proportion in the Medi-Cal served population was under-represented by over 23%. The number of Hispanic/Latinx served has increased over time with the percentage served increasing from
- African Americans showed an over-representation by 38% in the Medi-Cal served population.
- Asians/Pacific Islanders were the second smallest racial group among the county Medi-Cal eligible population. They were severely underserved by over 112%.

- Native Americans were the smallest racial group among the Medi-Cal eligible population in Riverside County. They were over-represented in served population by 34%.

Capacity to address disparities has been implemented across the department from outreach and community engagement to Workforce development. These efforts are described further within this plan update.

RUHS-BH Population Served CSS



| Estimated FSP population to be served | | | | |
|---|---|---|---|---|
| | Children | TAY | Adults | Older Adults |
| FY 24/25 | 1325 | 650 | 925 | 450 |
| FY 26/27 | 1350 | 700 | 950 | 460 |

**Strengths**

The department has multiple County-run clinics spread across the County's large geographic. Each region has increased capacity by adding contracted providers in each region of the County. Newer contractors including the Latino Commission and Special Services for Groups (SSG) have been established to broaden access especially for Latinx and Asian /Pacific Islanders. SSG primarily services Asian/Pacific islander families which is a growing demographic in the County; and as shown previously has a greater service disparity than other groups. RUHS-BH through PEI funding established Community Mental Health Promotor programs (CMHPP) for multiple race/ethnic groups and sub populations. The CMHPP program activities are further described in the PEI section of his report. The main goal of these program is to increase access, reduce barriers through mental health educational presentations and outreach. The groups served by CMHPP include; Latinx, Black/African American, Asian/Pacific Islander, Native American, Middle Eastern North African, LGBTQ+. Additional initiatives include contracting with cultural liaisons to support outreach to each race/ethic group and additional populations. These additional populations include; people with disabilities, deaf and hard of hearing (Riverside County has a significant Deaf Hard of Hearing community), faith-based community.

Additionally, RUHS-BH for many years has supported the implementation of evidenced based practices and has increased the infrastructure and capacity to provide evidenced-based interventions in various levels of the department's service array. MHSA Prevention and Early Intervention has implemented multiple evidenced based practices or evidenced informed interventions across the PEI service array. In CSS the RUHS-BH outpatient clinics provide the following Evidenced-Based Practices; including Dialectical Behavior Therapy (DBT), Seeking Safety, Trauma Focused-CBT, Wraparound, Multidimensional Family Therapy, First-Episode Psychosis coordinated Specialty Care model, Parent Child Interaction Therapy (PCIT) and Family Based Therapy (FBT) for eating disorders.

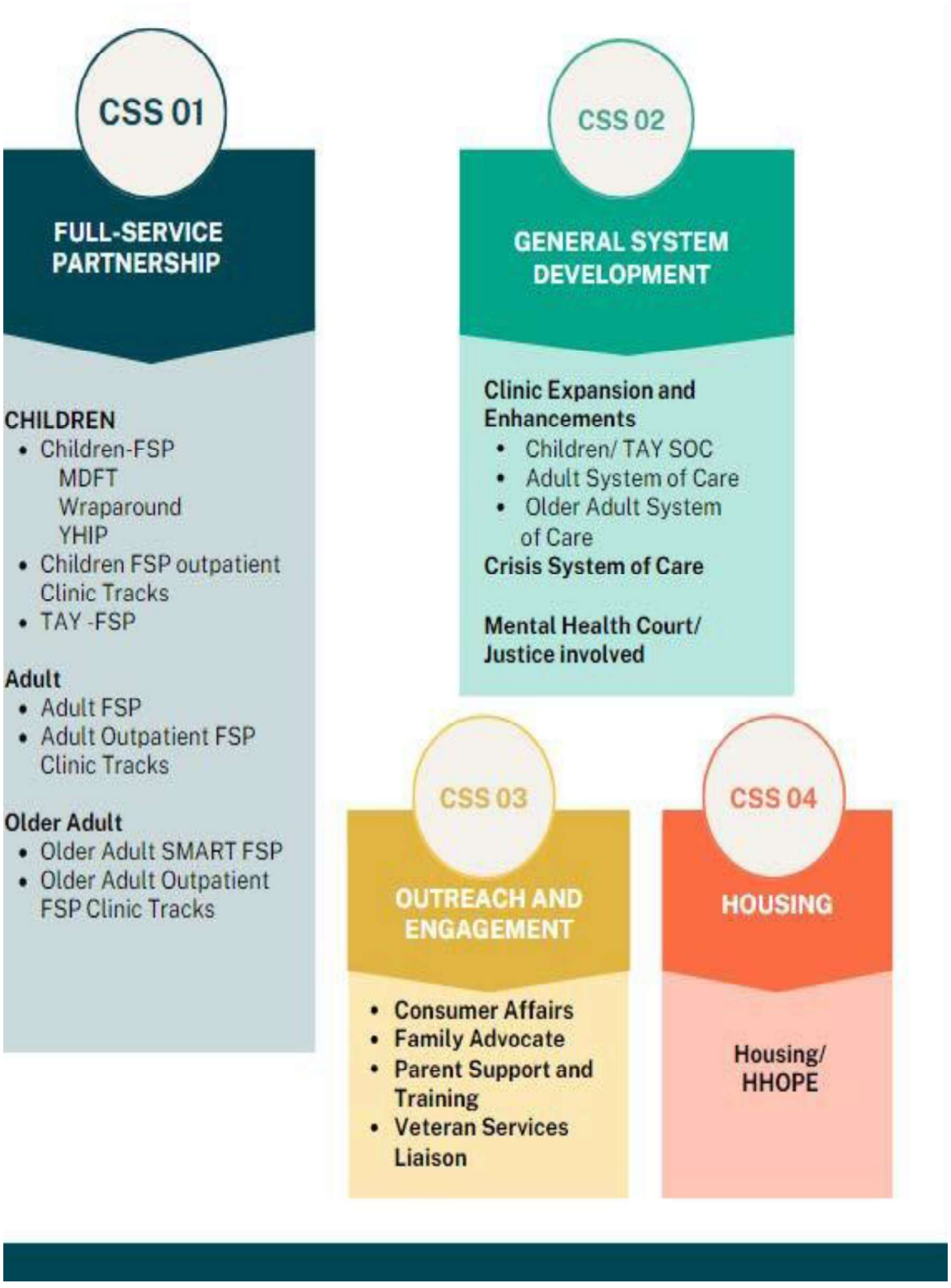
Challenges: Staff recruitment and retention has been a challenge over last few years, particularly post pandemic. Retaining staff that have been trained in evidenced based practices continues to be a challenge. Stigma and transportation are known barriers to accessing services.

# Section II

# Community Services and Supports

## MHSA Annual Updates FY25/26

# Community Services and Supports



# Community Services and Supports

***What is community services and supports (CSS)?***

CSS is the largest of the MHSA components. It is designed to provide all necessary mental health services to children, TAY, adults, and older adults with the most profound emotional, behavioral, or mental health challenges and for whom services under any other public or private insurance or other mental health or entitlement program is inadequate or unavailable. CSS contains provisions for Full-Service Partnership (FSP), Outreach and Engagement & Housing, and General System Development (GSD), which includes specialized programming for the Crisis System of Care, Justice Involved programs, and expansion and enhancement of the outpatient service system.

## CSS-01 Full-Service Partnerships

***what is a Full-Service Partnership (FSP)?***

Children Consumers, or youth and their families, enroll in a voluntary, intensive program that provides a broad range of supports to accelerate recovery or align with healthy development. FSP includes a "whatever-it-takes" commitment to progress on concrete behavioral health goals. FSP serves clients with a serious behavioral health diagnosis AND who are underserved and at risk of homelessness, incarceration, or hospitalization.

MENTAL HEALTH SERVICES ACT (MHSA)
FULL SERVICE PARTNERSHIP PROGRAM

# *Full-Service Partnership Children FSP Outcomes Report FY 2023-2024*

## Background

The following report is a summary of outcome data for the Children's Full Service Partnership (FSP) programs. The Childrens FSP programs provide intensive mental health services and are available in the Childrens County clinics and through a contracted provider. In addition an FSP providing Multi-Dimensional Family Therapy (MDFT) is available in each region of the County. FSP program outcomes are focused on evaluating changes in a consumer's status relative to several quality-of-life domains. Baseline histories are obtained from consumers at enrollment into the FSP program. Follow-up data is collected on a continuous basis for key life events (e.g., hospitalizations) and is assessed periodically for other select life domains.

Outcome reporting is based on comparisons between baseline and post-enrollment status and provides a measure of program effectiveness.

The following report is based on FSP data collection from consumers enrolled and served in the Children's FSP programs beginning July 1, 2023, and ending June 30, 2024. Baseline data for this report is based on responses from each of these consumer's Partnership Assessment Form, the history of events for the 12 months before a consumer began the FSP program.

Follow-up data used in this report is based on two sources. Psychiatric Hospital and Crisis emergency room data have been pulled from actual admissions to the hospital or crisis emergency room data. All other follow-up data used in this report was based on Key Event Tracking (KET) and Three Month Quarterly (3M) assessment forms completed on ImagineNet for these consumers during their enrollment in a Children's FSP program.

## FSP Program

The Children's Full Service Partnership (FSP) programs provide intensive mental health services for Children aged 0-15 and their families. FSP is a comprehensive and intensive mental health program and utilizes a "whatever it takes" field-based approach using innovative interventions to help people reach their recovery goals.

## Executive Summary

Children's FSP Enrollment and Demographics —During the 2023/2024 fiscal year from July 1, 2023 to June 30, 2024, a total of 1099 youth were served across 1157 enrollments which includes re-enrollments and transfers to one or more of the Children's FSP programs. The race/ethnicity of enrollees for this fiscal year was 565 (48.8%) Latinx, 164 (14.2%) White, and 103 (8.9%) African American/Black. Countywide, the most common diagnoses among YHIP FSP consumers was major depression 360 (33.1%). Countywide the largest proportion of consumers were between the ages of 11-14 (35%) and the majority enrolled were female (60%).

Children's FSP Discontinuances —Across all of the Children's FSP programs the most frequently reported discontinuance reason was 'Met goals' (41%).

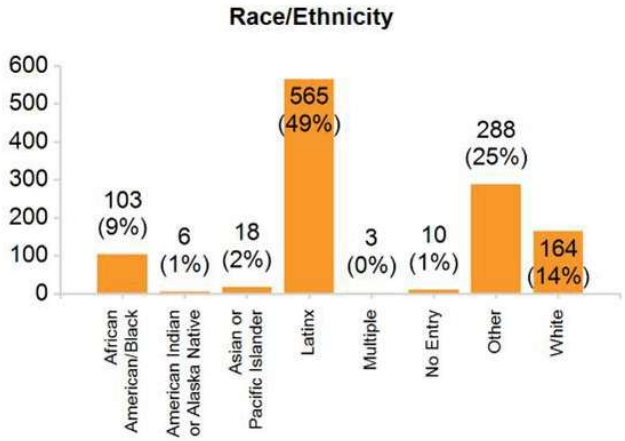
Children's FSP Services —In the 2023/2024 fiscal year, on average more than 42% of the Children's FSP consumers received 8 or more services a month. The highest average hours of services during 2023/2024 fiscal year were for intensive care coordination services (16.88 hours), individual therapy (12.26 hours) and intensive home based services (10.48 hours).

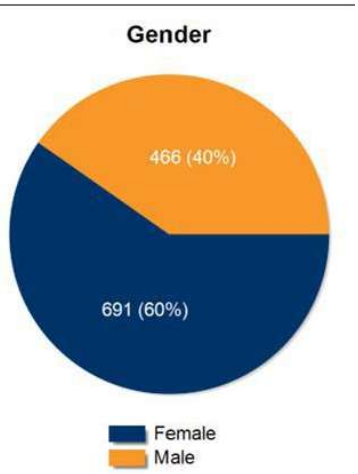
**Children's FSP Outcomes** —Follow-up data for all children's programs combined showed a decrease in arrests (92.52%), physical health emergency department visits (86.97%) and hospital admissions (15.70%) . The use of mental health crisis facilities increased slightly from intake to follow up.

A small percentage of consumers did not have a primary care physician at the beginning of the program (6.57%), however, more than half of those (50.67%) obtained one while in the FSP program. Of the youth with a co-occurring substance use problem who were not receiving treatment at intake,(35.00%) participated in substance use services while in partnership. An Additional 40 consumers were identified as having an active substance abuse problem during their participation in the FSP program.
Grades Improved or stayed above average from intake to follow-up: 65.53%. Attendance Improved or stayed above average from intake to follow-up:69.26%.

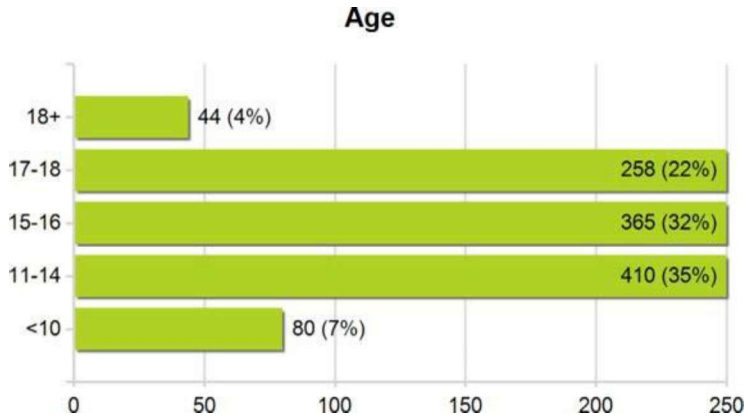
## Demographics & Diagnosis

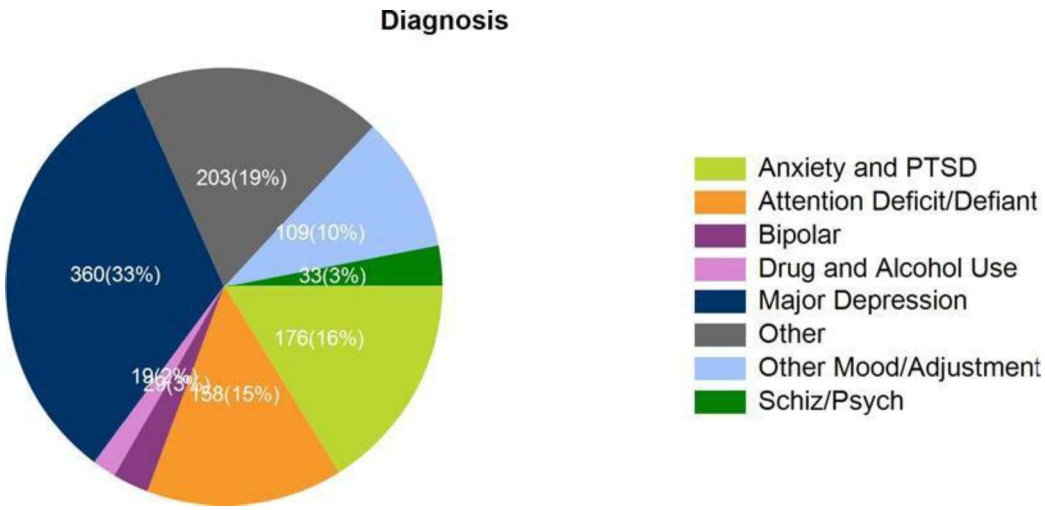
The majority served in the Children's FSP program in the 2023/2024 fiscal year were Latinx 49%, followed by Other Race, at 25%. The proportion of African American/Black participants was 9%. Also, more females (60%) have enrolled in the Children's FSP program than males (40%).




Most individuals served were between the age of 11-14 (35%) followed by 15-16 (32%). A large proportion of those served were diagnosed with Major Depression (33%).



## Length of FSP Partnership

The length of stay in years for those **1157** enrolled in Children's FSP programs during the 2023/2024 fiscal year is shown in the tables below. For reporting time in partnership, the total time a consumer spent in each enrollment is included.

The percentage of children with an active/open case having time in partnership longer than one year was 21%, while 84% of those without an open episodes have a time in partnership shorter than one year. Most of the Children's FSP consumers served in FY 2023/2024, had a length of stay less than two years (96%).

FSP re-entry: Of these **1157** FSP enrollments, 82 returned to an FSP program after discharging less than a year previously. These consumers are considered to have re-established partnership and 4 of them re-established partnership more than one time over their total time in partnership. The number of consumers that returned to an FSP program after more than a year had passed since discharging from an FSP program was 27.

| Youth Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| >= 1 Year and < 2 Years | 102 | 55 | 157 | 14% |
| >= 2 Years and <3 Years | 24 | 17 | 41 | 4% |
| >= 3 Years and < 4 Years | 1 | 1 | 2 | 0% |
| >= 90 days and < 1 Year | 268 | 158 | 426 | 37% |
| Under 90 days | 418 | 113 | 531 | 46% |
| **Total Consumer Enrollments** | **813** | **344** | **1157** | |

| | | | |
|---|---|---|---|
| **Average Years in Partnership** | 1.79 | 0.77 | 0.56 |
| **Median Years in Partnership** | 0.24 | 0.42 | 0.29 |
| **Maximum Years in Partnership** | 3.23 | 3.15 | 3.23 |

Length of stay for consumers enrolled in each program is described on the following pages. The length of stay in a program includes only time enrolled in that specific program. Some consumers were enrolled in more than one program during FY 2023/2024 fiscal year or left and returned within the same fiscal year.

*Note: Active cases include those with an open episode in an Children's FSP reporting unit as of 6/30/2024. Closed cases include only those that do not have an open episode in an FSP reporting unit as of 6/30/2024 . While some consumers leave partnership and later reestablish partnership in the same or different FSP program, time spent inactive is not included in this report.*

## Reason for Discontinuance of FSP

Upon termination of partnership a reason for discontinuance is selected. For recorded cases, consumers most often closed because the consumer met goals (41%). The next highest proportion of consumers were noted to have voluntarily left the program. (30%). Partner cannot be located accounted for 14% of discontinuance reasons. If a consumer terminated partnership more than once, each instance was recorded in this table.

| Discontinuation Reason | Count | % |
|---|---|---|
| **Justice system** | 2 | 0% |
| **Met goals** | 275 | 41% |
| **Moved out of county/area** | 72 | 11% |
| **Needs residential care** | 9 | 1% |
| **Other** | 4 | 1% |
| **Partner cannot be located** | 94 | 14% |
| **Partner left program** | 206 | 30% |
| **Target criteria not met** | 14 | 2% |
| **Total** | **676** | **100%** |

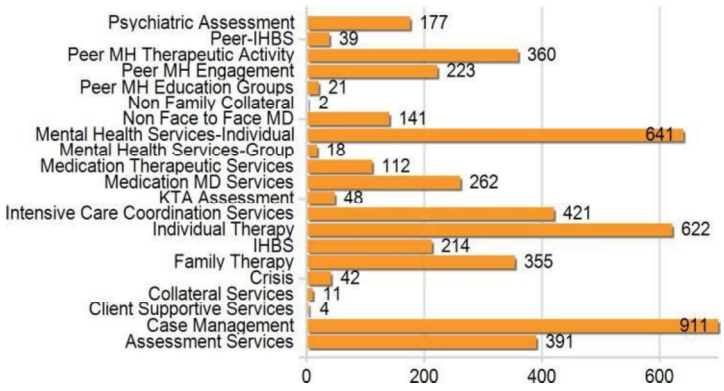
## Service Frequency By Month

The table below shows the number of individuals receiving various amounts of services per month, for each of month of the 2023/2024 fiscal year. The majority of consumers received either 8-13, or 4-7 services per month within the fiscal year. On average, more than 42% of Children's FSP consumers received 8 or more services per month.

| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 63 (14%) | 53 (12%) | 47 (12%) | 42 (10%) | 45 (12%) | 44 (11%) | 41 (10%) | 48 (12%) | 36 (9%) | 58 (14%) | 41 (10%) | 49 (13%) |
| 2-3 | 98 (22%) | 59 (13%) | 81 (20%) | 84 (21%) | 63 (17%) | 86 (22%) | 75 (19%) | 75 (19%) | 91 (22%) | 68 (16%) | 69 (17%) | 83 (22%) |
| 4-7 | 125 (28%) | 113 (25%) | 83 (21%) | 114 (28%) | 107 (29%) | 115 (29%) | 102 (26%) | 105 (26%) | 106 (26%) | 118 (28%) | 126 (30%) | 109 (30%) |
| 8-13 | 90 (20%) | 117 (26%) | 116 (29%) | 82 (20%) | 85 (23%) | 91 (23%) | 93 (24%) | 102 (26%) | 95 (23%) | 89 (21%) | 88 (21%) | 71 (19%) |
| 14-19 | 33 (7%) | 54 (12%) | 46 (11%) | 48 (12%) | 33 (9%) | 35 (9%) | 36 (9%) | 36 (9%) | 40 (10%) | 40 (9%) | 51 (12%) | 29 (8%) |
| 20-25 | 20 (5%) | 28 (6%) | 18 (4%) | 17 (4%) | 21 (6%) | 18 (5%) | 24 (6%) | 16 (4%) | 25 (6%) | 24 (6%) | 24 (6%) | 17 (5%) |
| 26-31 | 8 (2%) | 15 (3%) | 6 (1%) | 16 (4%) | 13 (4%) | 3 (1%) | 11 (3%) | 9 (2%) | 9 (2%) | 13 (3%) | 6 (1%) | 5 (1%) |
| 32+ | 7 (2%) | 10 (2%) | 5 (1%) | 3 (1%) | 3 (1%) | 3 (1%) | 11 (3%) | 9 (2%) | 12 (3%) | 16 (4%) | 10 (2%) | 6 (2%) |
| Monthly Total | 444 | 449 | 402 | 406 | 370 | 395 | 393 | 400 | 414 | 426 | 415 | 369 |

## Service Detail

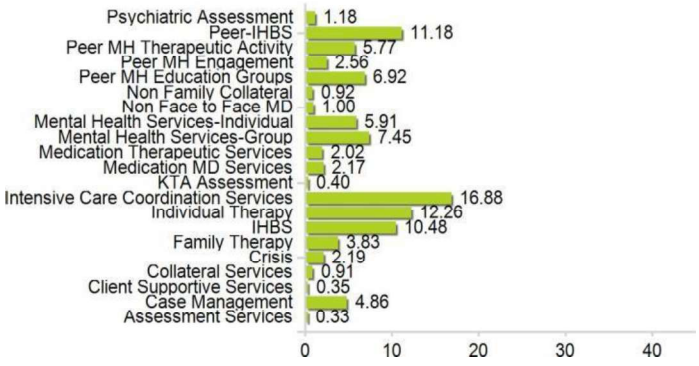
### Total Clients Served Per Type of Service




During the 2023/2024 fiscal year, case management, individual mental health services and individual therapy were the three services that served the most consumers.

The average number of hours consumers received of each type of service while in Children's FSP programs during the 2023/2024 fiscal year was calculated. As shown to the right, the average number of hours per consumer was highest in intensive care coordination services (16.88 hours).

### Average Hours Per Client Per Type of Service




| Type of Service | # of Youth | % of Youth | # of Svcs | Avg. # Svcs |
|---|---|---|---|---|
| Assessment Services | 391 | 34% | 504 | 1.29 |
| Case Management | 911 | 79% | 7,350 | 8.07 |
| Client Supportive Services | 4 | 0% | 4 | 1.00 |
| Collateral Services | 11 | 1% | 17 | 1.55 |
| Crisis | 42 | 4% | 69 | 1.64 |
| Family Therapy | 355 | 31% | 1,725 | 4.86 |
| IHBS | 214 | 18% | 1,997 | 9.33 |
| Individual Therapy | 622 | 54% | 8,517 | 13.69 |
| Intensive Care Coordination Services | 421 | 36% | 10,985 | 26.09 |
| KTA Assessment | 48 | 4% | 76 | 1.58 |
| Medication MD Services | 262 | 23% | 912 | 3.48 |
| Medication Therapeutic Services | 112 | 10% | 606 | 5.41 |
| Mental Health Services-Group | 18 | 2% | 109 | 6.06 |
| Mental Health Services-Individual | 641 | 55% | 4,323 | 6.74 |
| Non Face to Face MD | 141 | 12% | 374 | 2.65 |
| Non Family Collateral | 2 | 0% | 4 | 2.00 |
| Peer MH Education Groups | 21 | 2% | 98 | 4.67 |
| Peer MH Engagement | 223 | 19% | 402 | 1.80 |
| Peer MH Therapeutic Activity | 360 | 31% | 2,534 | 7.04 |
| Peer-IHBS | 39 | 3% | 343 | 8.79 |
| Psychiatric Assessment | 177 | 15% | 195 | 1.10 |

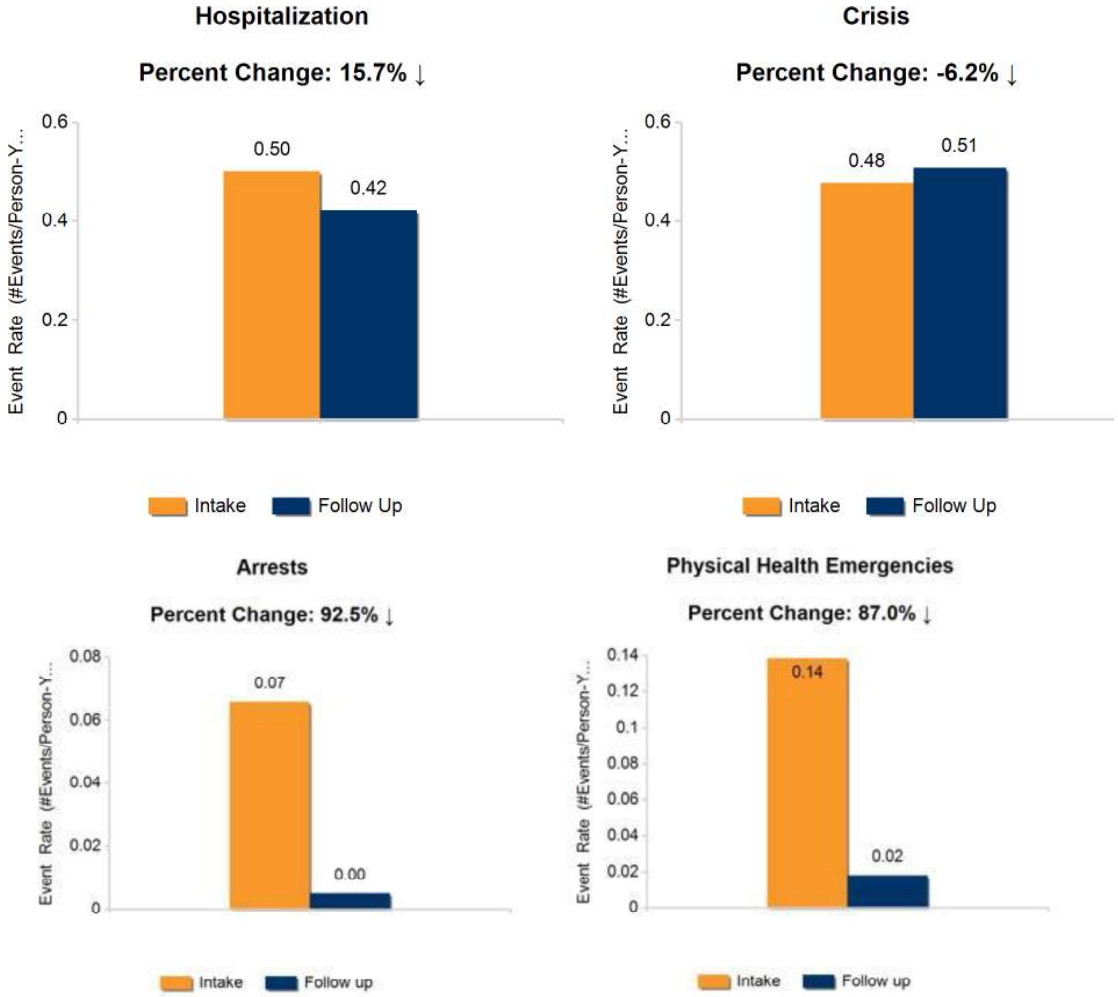
## Outcomes

Primary outcomes of interest for FSP include arrests, physical and mental health emergency room visits, incidences of acute hospitalizations and long-term care. The number of events in the 12 months prior to FSP enrollment are compared with the rate of 'number of events per person-year' in the program (i.e., follow-up). At follow-up, the number of outcome events occurring while enrolled was summed and divided by the years all individuals had been in the program. Actual counts for each outcome overall and by program can be found after page 12.

Overall, hospitalizations, arrests, and physical health emergency visits have reduced.

## Outcomes

Additional primary outcomes of interest include expulsion and suspension rates. Grades achieved in school are another outcome measure for FSP youth. Intake data reflects the grades reported on the PAF form upon enrollment. Data on grades is recorded quarterly with the first follow-up data collection point 90 days after enrollment in the FSP. Follow-up data on grades used in these analyses is the most currently reported quarterly data.

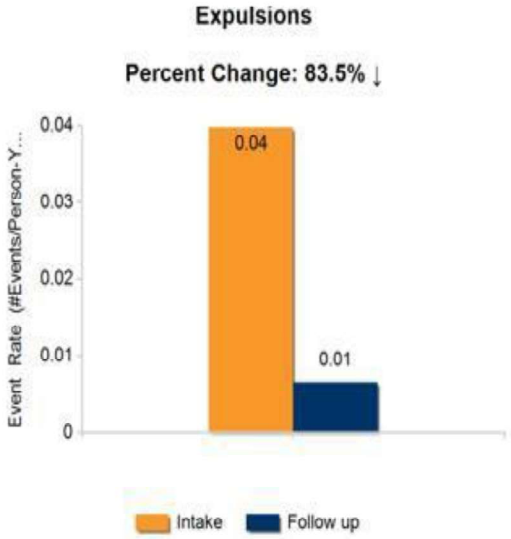



Arrests decreased 92.5% from intake to follow-up.

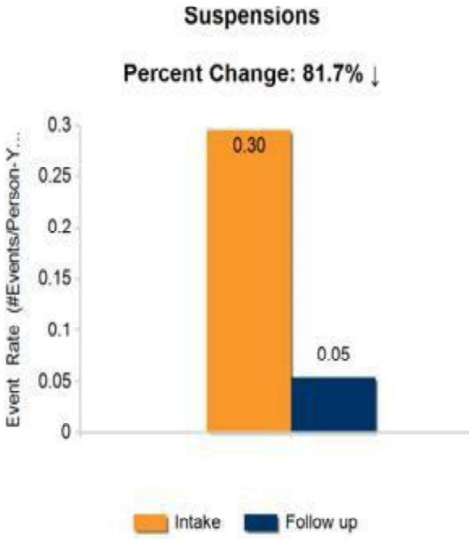
Physical Health Emergency visits decreased 87.0%.

## Outcomes: Residential

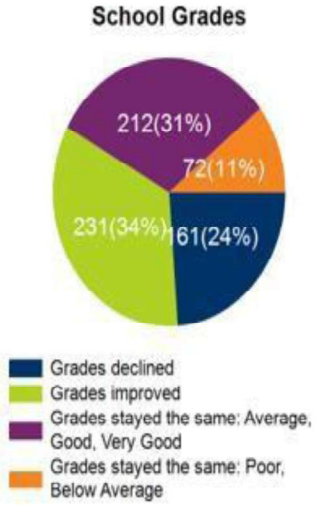
Overall, expulsions and suspensions both decreased. Analysis of school grades at follow-up is done using pre-to post matched pairs and reflects directional change from baseline to follow- up. In some cases follow-up data is missing.



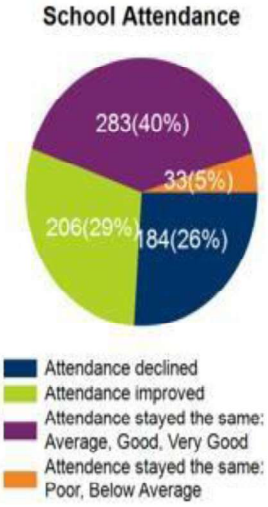

Expulsions decreased 83.5% from intake to follow-up.




Suspension decreased 81.7% from intake follow-up.



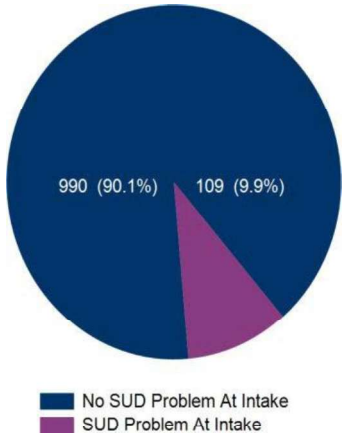

Grades Improved or stayed above average from intake to follow-up: 65.53%

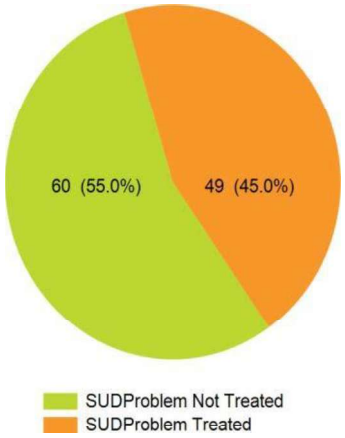



Attendance Improved or stayed above average from intake to follow-up:69.26%.

## Outcomes: Substance Use

Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (9.9%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

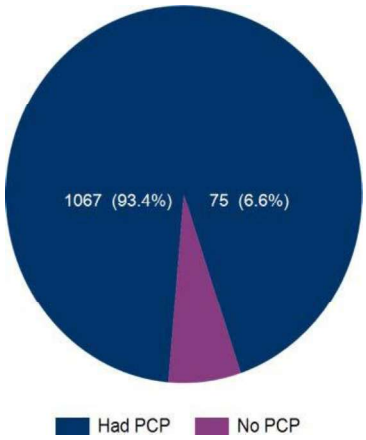



Follow-up: Based on follow-up data reported quarterly, 35.0% (21) of the 60 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 40 consumers not identified at intake were noted to have an SU problem on follow-up and 60.0% of them were reported to be in SU services on follow-up.

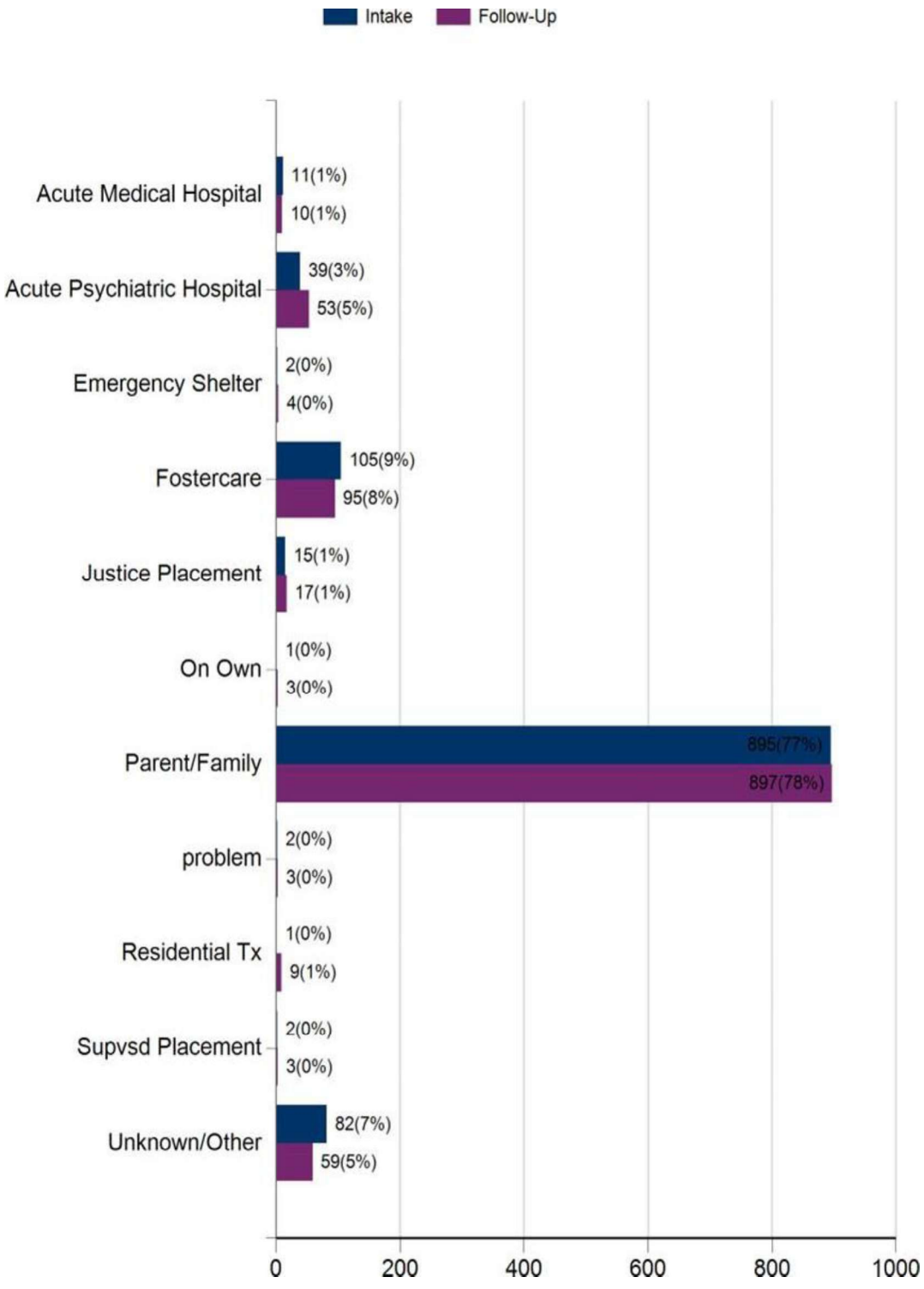
## Outcomes: Primary Care Physician

Intake: (6.6%) of youth did not have a primary care physician (PCP) at intake.




Follow-up: Of the 75 consumers that did not have a PCP at intake, 38 (50.7%) obtained a PCP while in the program.

Residential settings was calculated using the residential category from intake to their latest residential status. The percentages below are for all Children's FSP reporting


Intake
Follow-Up
Acute Medical Hospital
11(1%)
10(1%)
Acute Psychiatric Hospital
39(3%)
53(5%)
Emergency Shelter
2(0%)
4(0%)
Fostercare
105(9%)
95(8%)
Justice Placement
15(1%)
17(1%)
On Own
1(0%)
3(0%)
Parent/Family
895(77%)
897(78%)
problem
2(0%)
3(0%)
Residential Tx
1(0%)
9(1%)
Supvsd Placement
2(0%)
3(0%)
Unknown/Other
82(7%)
59(5%)
0
200
400
600
800
1000

## Outcomes: Residential Days

The following compares consumers' living arrangements in the year prior to FSP enrollment to their living arrangements while enrolled in the program. Specifically, the number of days spent in each setting in the year before enrollment is compared to the number of days they spent annually in each setting during enrollment. The goal of this analysis is to determine whether days in more stable settings during FSP participation had increased and days in less stable settings had decreased.

Baseline data was obtained from consumers' Partnership Assessment Form which includes the number of days consumers spent in each residential setting during the 12 months immediately prior to enrollment. Note that this 12 months preceded their first enrollment to any FSP program.

The number of days the consumers spent in each setting while enrolled in an FSP program was tracked through enrollment changes and residence changes noted on Key Event Tracking (KET) forms. When consumers re-enter an FSP program after a lapse in enrollment, their living arrangement is often noted on a KET form or new PAF, but if not, it was considered unknown. To accurately compare a year of pre-enrollment with a year of post enrollment, data for residential

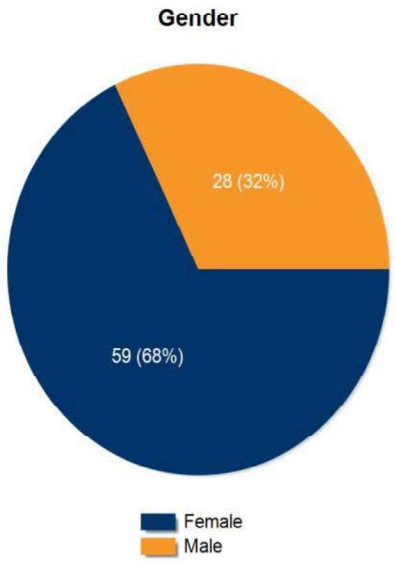
days during enrollment has been annualized.

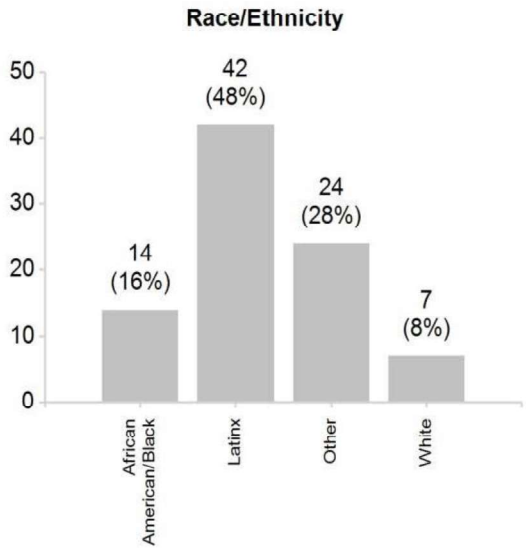
| | 12 Months Prior to Enrollment | | Annualized Days During Enrollment | | |
|---|---|---|---|---|---|
| **Living Situation** | **# of Days** | **Count (n)** | **# of Days** | **Count (n)** | **Percent change (%)** |
| Acute Medical Hospital | 1,064 | 51 | 1,459 | 17 | 37% |
| Acute Psychiatric Hospital | 2,988 | 390 | 8,517 | 125 | 185% |
| Community Treatment Facility | 45 | 3 | 271 | 2 | 502% |
| Emergency Shelter | 816 | 6 | 632 | 6 | -23% |
| Fostercare | 18,990 | 73 | 36,032 | 73 | 90% |
| Homeless | 437 | 4 | - | 0 | -100% |
| Jail/Prison | 31 | 2 | - | 0 | -100% |
| Justice Placement | 5,536 | 42 | 3,353 | 24 | -39% |
| On Own | 730 | 2 | 1,375 | 6 | 88% |
| Parent/Family | 341,457 | 986 | 304,314 | 985 | -11% |
| Residential Tx | 557 | 10 | 1,535 | 12 | 176% |
| State Hospital | 199 | 13 | - | 0 | -100% |
| Supervised Placement | 924 | 4 | 1,501 | 8 | 62% |
| Unknown/Other | 48,532 | 138 | 42,410 | 138 | -13% |

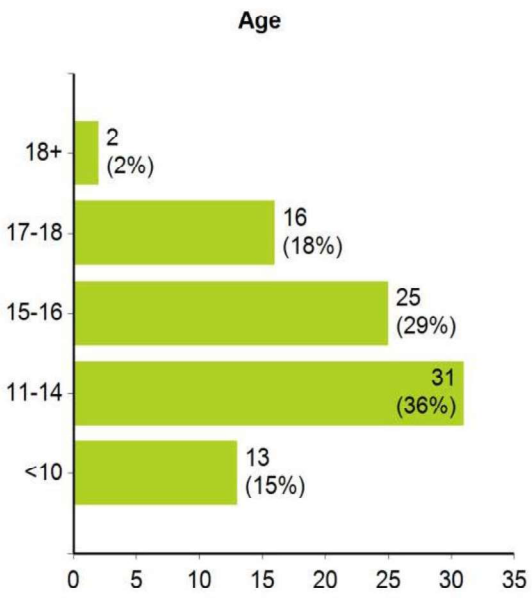
**Children's FSP demographics and Outcomes for: 33AHFC**
**Served by this reporting unit: 84 Enrollment: 87**

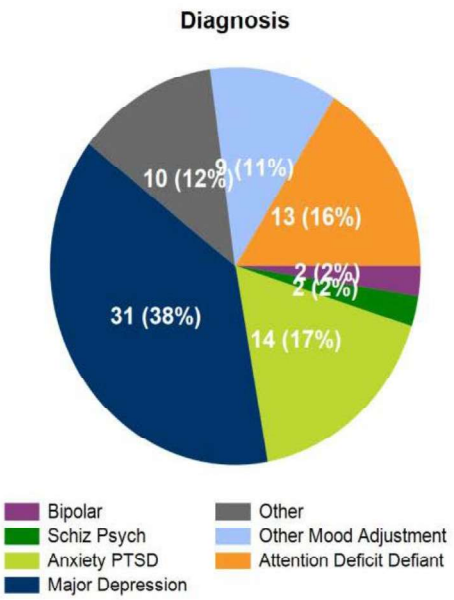
## Demographics

32% of consumers were male and 68% were female.
48% of consumers were Latinx, 8% of consumers were White and 16% of consumers were Black/African American.
29% of consumers were 15 to 16 years old.



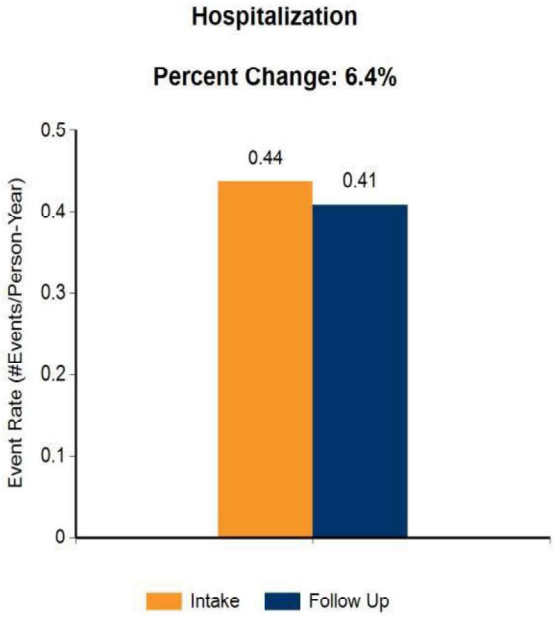



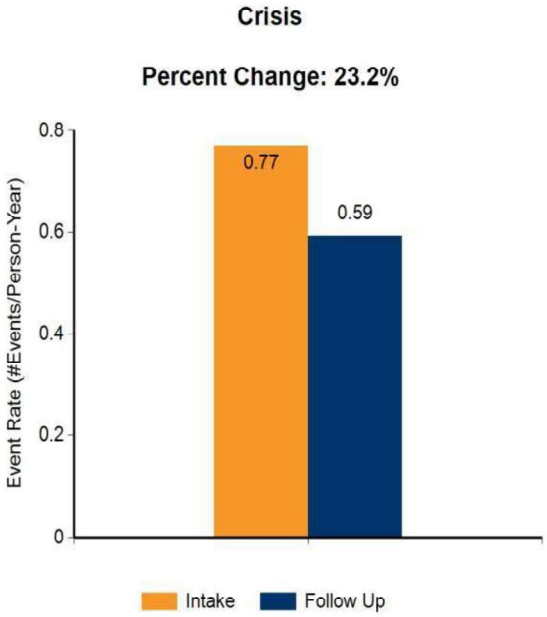



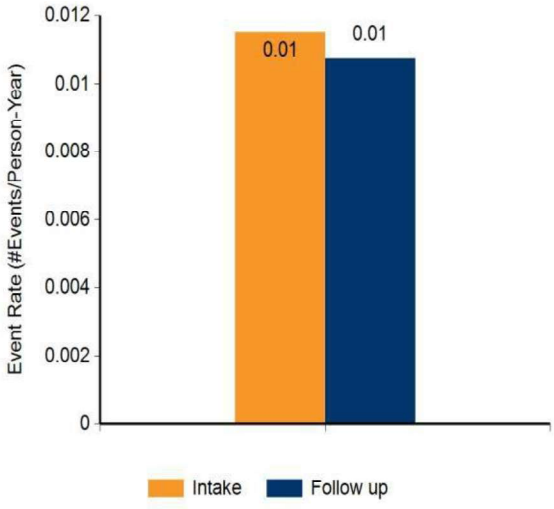



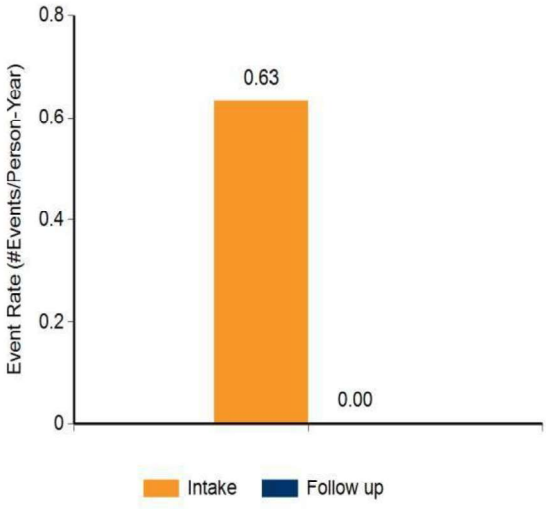
## Outcomes for 33AHFC

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.



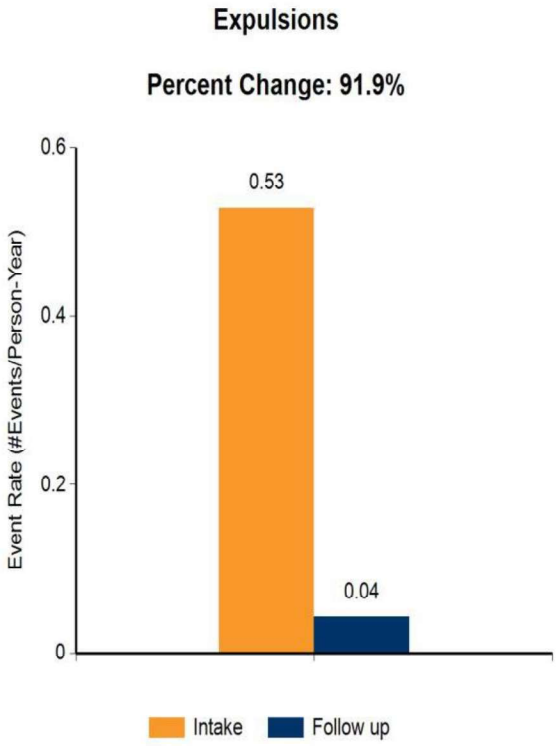



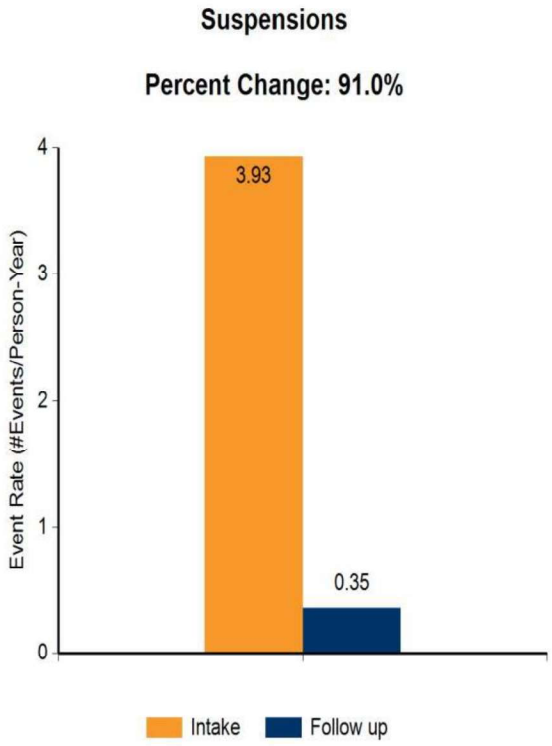



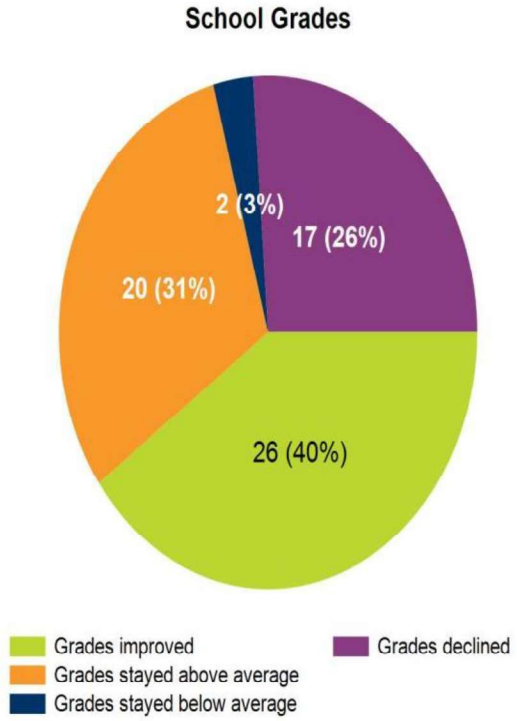



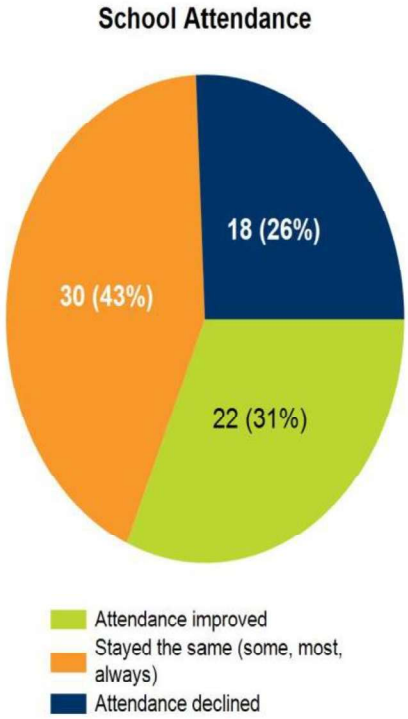
## Outcomes for 33AHFC (cont.)

Additional primary outcomes of interest include expulsion and suspension rates, along with school grades and school attendance.

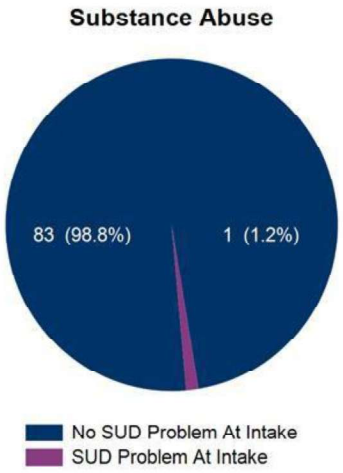


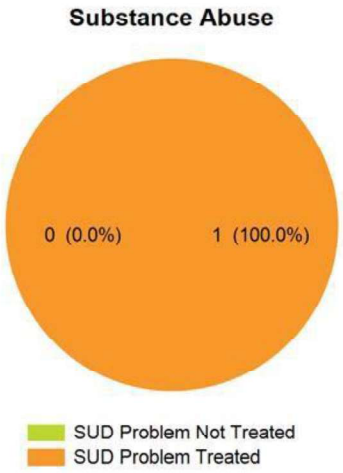



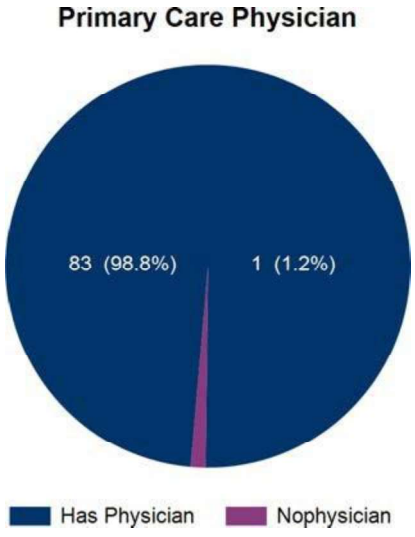
## Outcomes: Substance Use 33AHFC




Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (1.2%). The majority of those who had co-occurring MH and SU problems, had been receiving SU treatment services at intake.
An additional 4 consumers not identified at intake were noted to have an SU problem on follow-up and 0.0% of them were reported to be in SU services on follow-up.

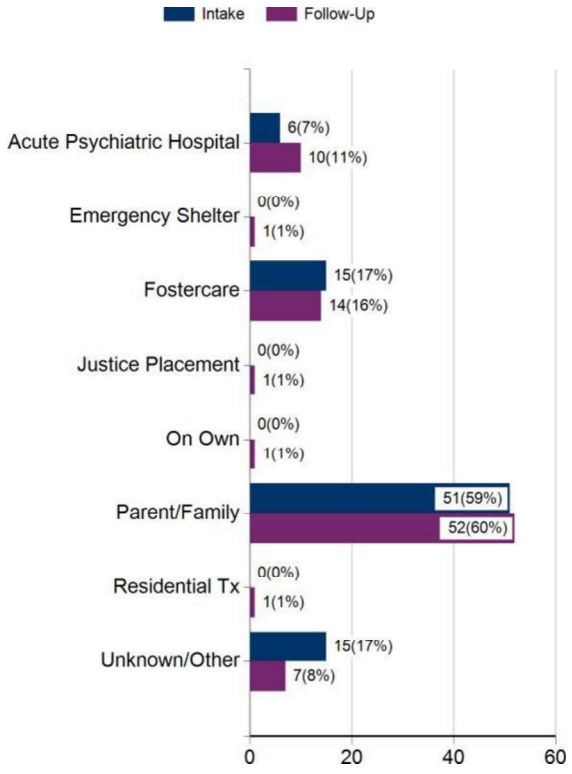
## Outcomes: Primary Care Physician 33AHFC




Intake: Most consumers (1.2%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 1 consumers that did not have a PCP at intake, 1 (100.0%) obtained a PCP while in the program.

## Outcomes: Residential & Discontinuance (33AHFC)




| Discontinuation Reason | Count | % |
|---|---|---|
| Met goals | 43 | 62% |
| Moved out of county/area | 5 | 7% |
| Needs residential care | 1 | 1% |
| Partner cannot be located | 10 | 14% |
| Partner left program | 10 | 14% |
| **Total** | **69** | **100%** |

## Length of FSP Partnership for: 33AHFC

| Youth Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| >= 1 Year and < 2 Years | 28 | 2 | 30 | 34.48% |
| >= 2 Years and <3 Years | 9 | 1 | 10 | 11.49% |
| >= 3 Years and < 4 Years | 1 | 0 | 1 | 1.15% |
| >= 90 days and < 1 Year | 21 | 11 | 32 | 36.78% |
| Under 90 days | 8 | 6 | 14 | 16.09% |
| **Total Consumer Enrollments** | **67** | **20** | **87** | |

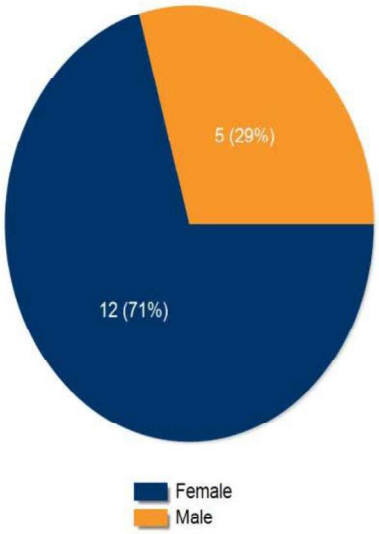
## Service Detail: 33AHFC

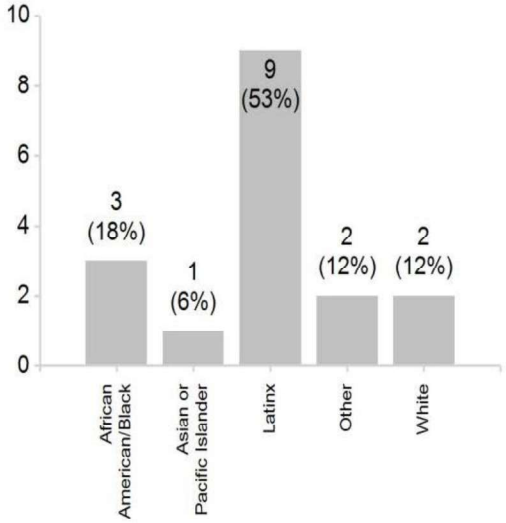
| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 7 (13%) | 6 (11%) | 9 (17%) | 5 (11%) | 6 (18%) | 6 (18%) | 7 (21%) | 0 (0%) | 1 (3%) | 1 (4%) | 1 (3%) | 1 (5%) |
| 2-3 | 21 (38%) | 8 (14%) | 12 (23%) | 13 (30%) | 7 (21%) | 11 (32%) | 12 (35%) | 10 (32%) | 11 (38%) | 4 (16%) | 6 (21%) | 5 (24%) |
| 4-7 | 17 (30%) | 23 (40%) | 17 (32%) | 17 (39%) | 14 (42%) | 11 (32%) | 8 (24%) | 14 (45%) | 11 (38%) | 13 (52%) | 15 (52%) | 9 (43%) |
| 8-13 | 9 (16%) | 14 (25%) | 14 (26%) | 6 (14%) | 5 (15%) | 6 (18%) | 4 (12%) | 6 (19%) | 5 (17%) | 5 (20%) | 3 (10%) | 5 (24%) |
| 14-19 | 1 (2%) | 5 (9%) | 1 (2%) | 2 (5%) | 1 (3%) | 0 (0%) | 3 (9%) | 1 (3%) | 1 (3%) | 2 (8%) | 2 (7%) | 1 (5%) |
| 20-25 | 0 (0%) | 1 (2%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (3%) | 0 (0%) |
| 26-31 | 1 (2%) | 0 (0%) | 0 (0%) | 1 (2%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| 32+ | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (3%) | 0 (0%) |
| Monthly Total | 56 | 57 | 53 | 44 | 33 | 34 | 34 | 31 | 29 | 25 | 29 | 21 |

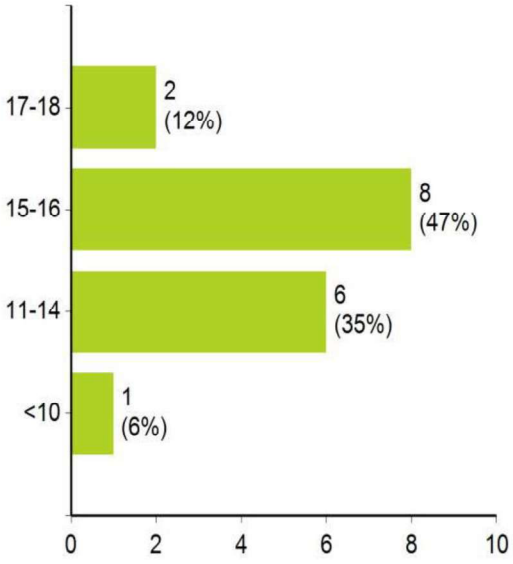
| Type of Service | # of Youth | % of Youth | # of Svcs | Avg. # Svcs |
|---|---|---|---|---|
| Case Management | 74 | 19% | 433 | 5.85 |
| Crisis | 2 | 1% | 2 | 1.00 |
| Family Therapy | 30 | 8% | 78 | 2.60 |
| IHBS | 1 | 0% | 2 | 2.00 |
| Individual Therapy | 75 | 19% | 947 | 12.63 |
| Intensive Care Coordination Services | 25 | 6% | 165 | 6.60 |
| Medication MD Services | 34 | 9% | 86 | 2.53 |
| Medication Therapeutic Services | 36 | 9% | 104 | 2.89 |
| Mental Health Services-Group | 6 | 2% | 75 | 12.50 |
| Mental Health Services-Individual | 27 | 7% | 92 | 3.41 |
| Non Face to Face MD | 40 | 10% | 170 | 4.25 |
| Peer MH Education Groups | 4 | 1% | 15 | 3.75 |
| Peer MH Engagement | 5 | 1% | 5 | 1.00 |
| Peer MH Therapeutic Activity | 27 | 7% | 210 | 7.78 |
| Peer-IHBS | 1 | 0% | 1 | 1.00 |
| Psychiatric Assessment | 3 | 1% | 3 | 1.00 |

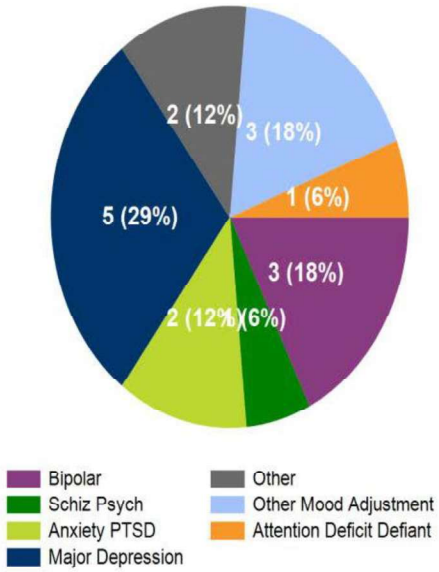
**Children's FSP demographics and Outcomes for: 3357FC**
**Served by this reporting unit: 17 Enrollment: 17**

29% of consumers were male and 71% were female.
53% of consumers were Latinx, 12% of consumers were White and 18% of consumers were Black/African American.
47% of consumers were 15 to 16 years old.



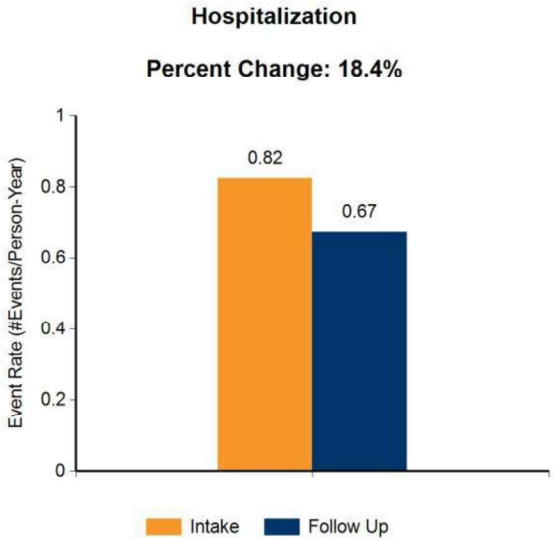



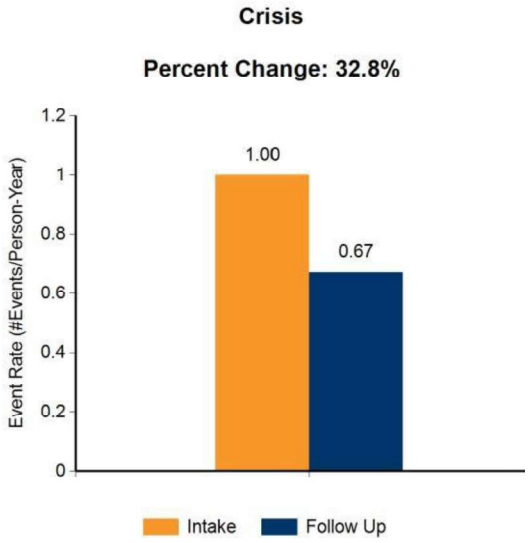



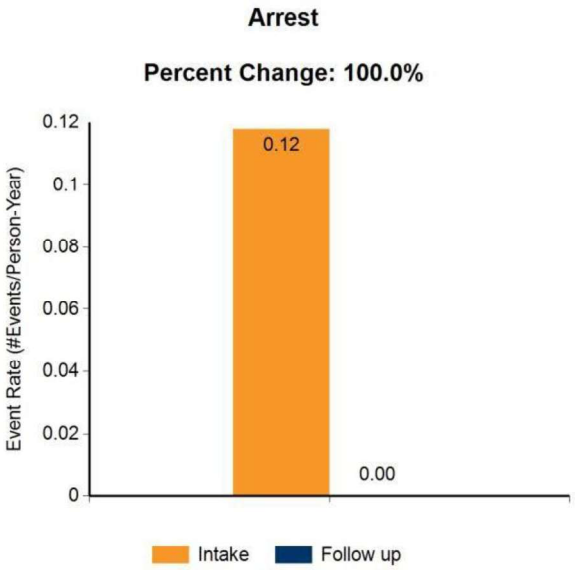



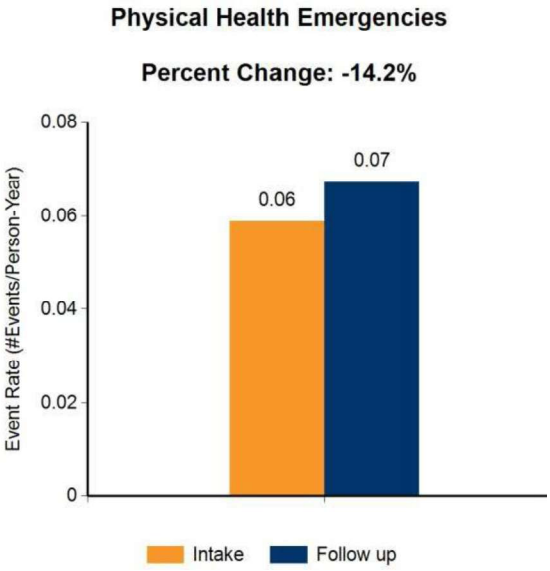
## Outcomes for 3357FC

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

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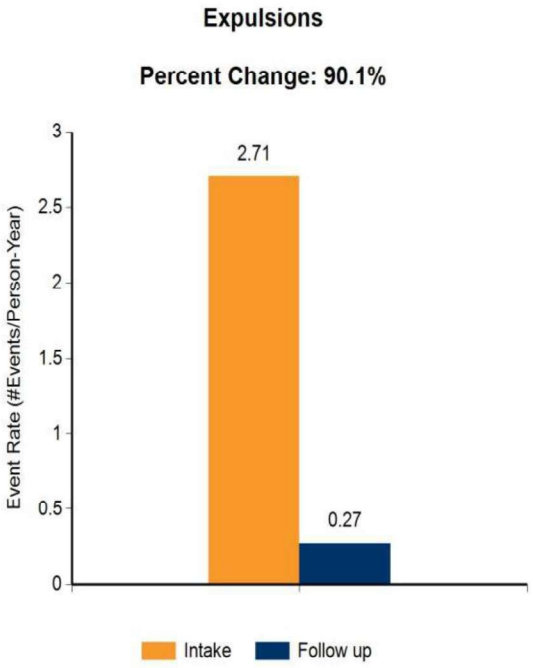
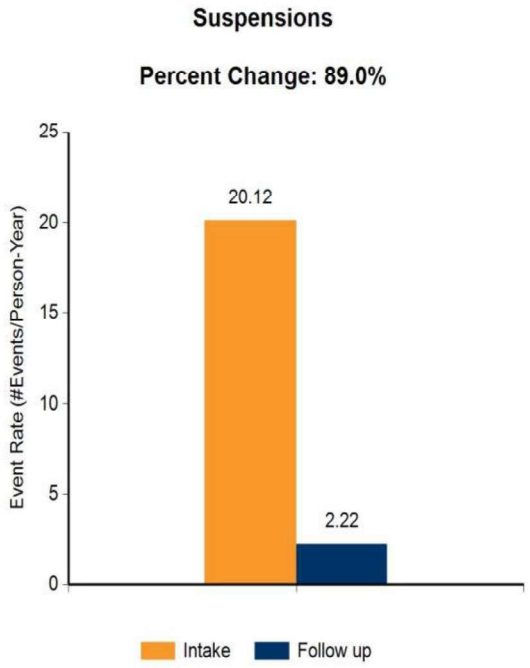
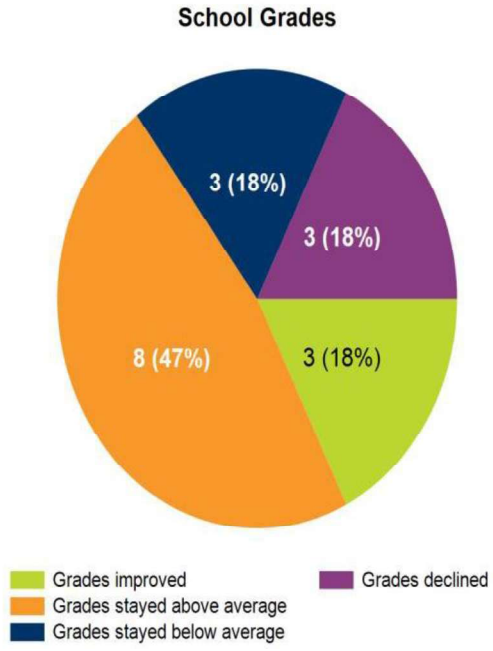
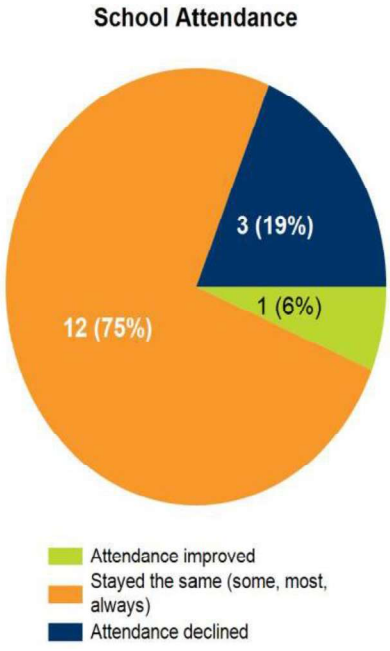
## Outcomes for 3357FC (cont.)

Additional primary outcomes of interest include expulsion and suspension rates, along with school grades and school attendance.

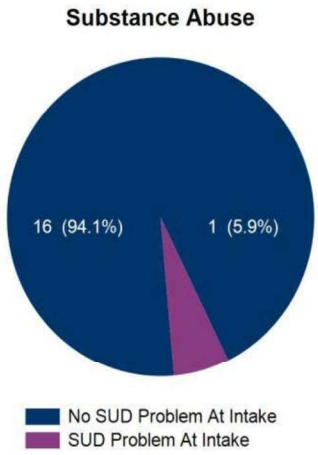


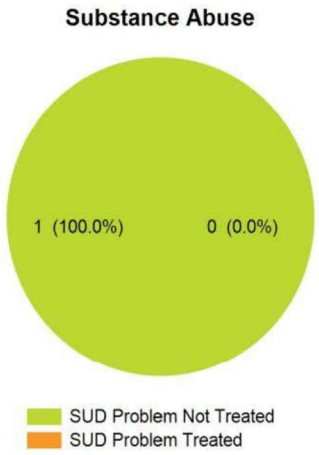



## Outcomes: Substance Use 3357FC

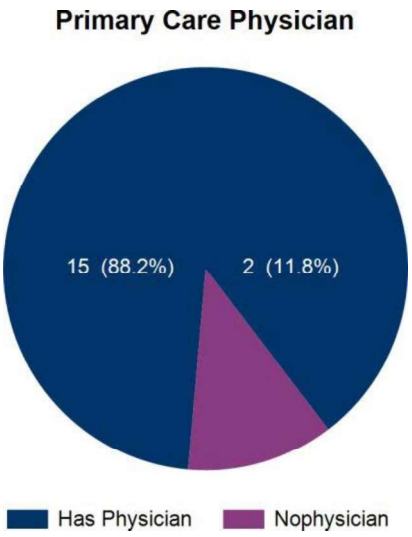



Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (5.9%). The majority of those who had co-occurring MH and SU problems, had been receiving SU treatment services at intake.

An additional 0 consumers not identified at intake were noted to have an SU problem on follow-up and 0.0% of them were reported to be in SU services on follow-up.

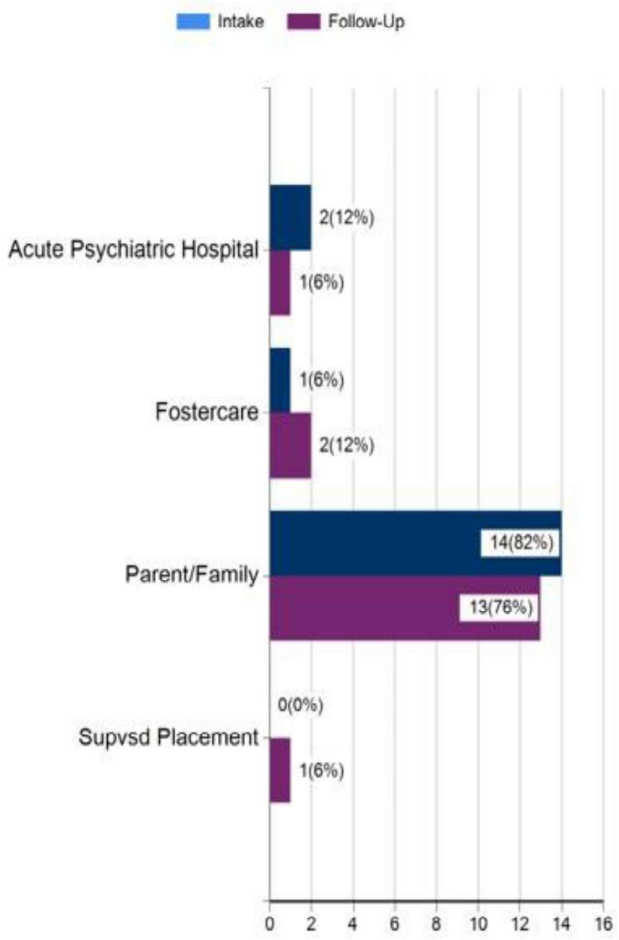
## Outcomes: Primary Care Physician 3357FC




Intake: Most consumers (11.8%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 2 consumers that did not have a PCP at intake, 2 (100.0%) obtained a PCP while in the program.

## Outcomes: Residential & Discontinuance (3357FC)




| Discontinuation Reason | Count | % |
|---|---|---|
| Met goals | 1 | 17% |
| Moved out of county/area | 1 | 17% |
| Partner cannot be located | 2 | 33% |
| Partner left program | 2 | 33% |
| Total | 6 | 100% |

## Length of FSP Partnership for: 3357FC

| Youth Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| >= 1 Year and < 2 Years | 1 | 0 | 1 | 5.88% |
| >= 2 Years and <3 Years | 3 | 0 | 3 | 17.65% |
| >= 90 days and < 1 Year | 5 | 5 | 10 | 58.82% |
| Under 90 days | 2 | 1 | 3 | 17.65% |
| Total Consumer Enrollments | 11 | 6 | 17 | |

## Service Detail: 3357FC

| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 1 (25%) | 1 (25%) | 0 (0%) | 1 (20%) | 2 (33%) | 2 (33%) | 3 (38%) | 1 (13%) | 3 (27%) | 3 (27%) | 2 (22%) | 1 (20%) |
| 2-3 | 1 (25%) | 1 (25%) | 1 (50%) | 1 (20%) | 2 (33%) | 1 (17%) | 2 (25%) | 2 (25%) | 3 (27%) | 2 (18%) | 1 (11%) | 2 (40%) |
| 4-7 | 2 (50%) | 2 (50%) | 0 (0%) | 2 (40%) | 2 (33%) | 3 (50%) | 2 (25%) | 4 (50%) | 5 (45%) | 5 (45%) | 5 (56%) | 2 (40%) |
| 8-13 | 0 (0%) | 0 (0%) | 1 (50%) | 1 (20%) | 0 (0%) | 0 (0%) | 1 (13%) | 1 (13%) | 0 (0%) | 1 (9%) | 1 (11%) | 0 (0%) |
| Monthly Total | 4 | 4 | 2 | 5 | 6 | 6 | 8 | 8 | 11 | 11 | 9 | 5 |

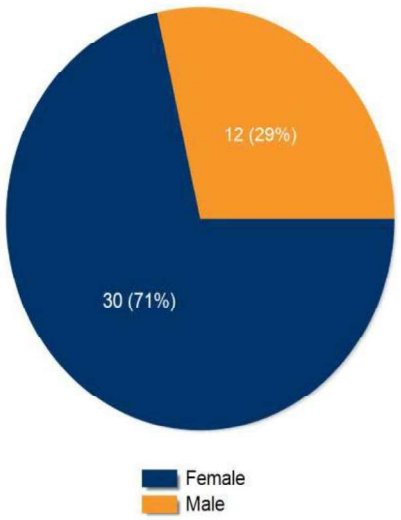
| Type of Service | # of Youth | % of Youth | # of Svcs | Avg. # Svcs |
|---|---|---|---|---|
| Assessment Services | 1 | 1% | 1 | 1.00 |
| Case Management | 8 | 11% | 29 | 3.63 |
| Crisis | 1 | 1% | 1 | 1.00 |
| Family Therapy | 7 | 10% | 8 | 1.14 |
| IHBS | 1 | 1% | 2 | 2.00 |
| Individual Therapy | 9 | 13% | 123 | 13.67 |
| Intensive Care Coordination Services | 7 | 10% | 21 | 3.00 |
| Medication MD Services | 9 | 13% | 11 | 1.22 |
| Mental Health Services-Individual | 13 | 19% | 55 | 4.23 |
| Non Face to Face MD | 6 | 9% | 21 | 3.50 |
| Peer MH Therapeutic Activity | 7 | 10% | 24 | 3.43 |
| Peer-IHBS | 1 | 1% | 1 | 1.00 |

## Children's FSP demographics and Outcomes for:
## 33MOFC Served by this reporting unit: 42

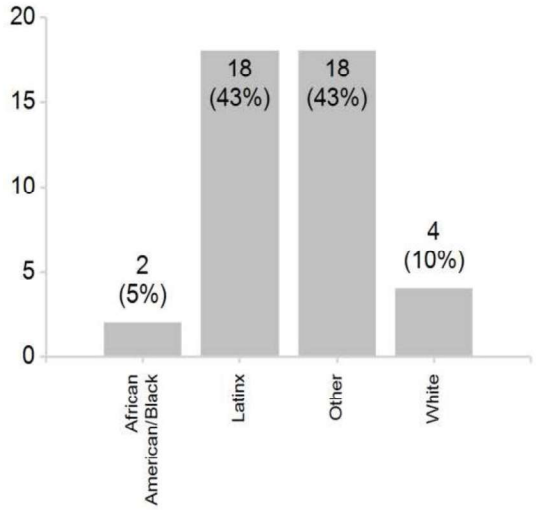
### Demographics

29% of consumers were male, and 71% were female.
43% of consumers were Latinx, 10% of consumers were White, and 5% of consumers were Black/African American.
29% of consumers were 15 to 16 years old.

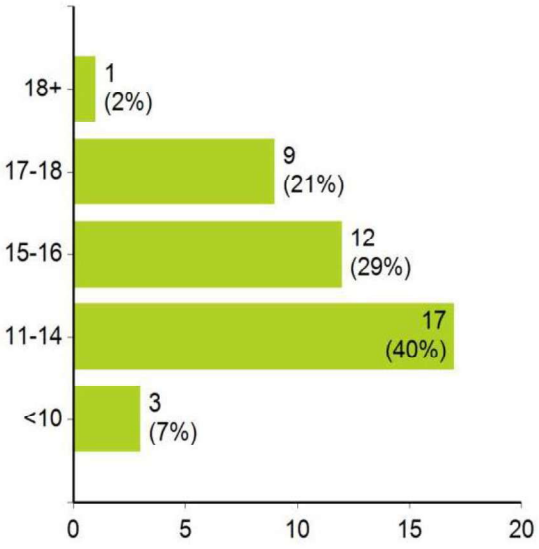
**Gender**



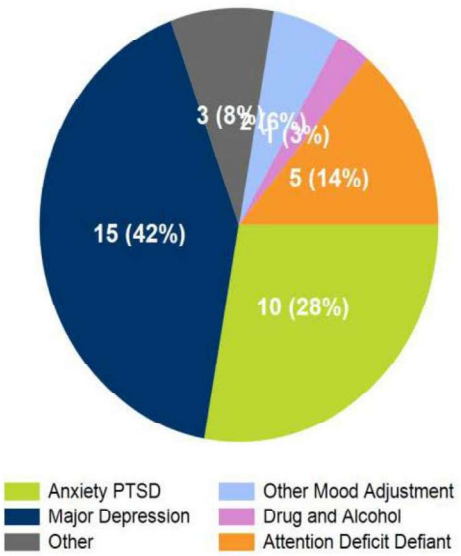

**Race/Ethnicity**




**Age**

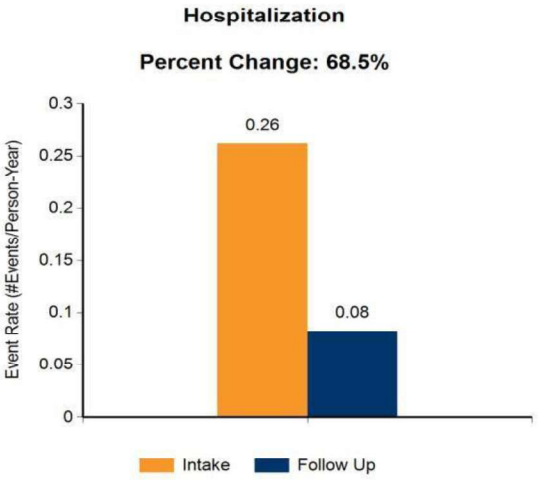


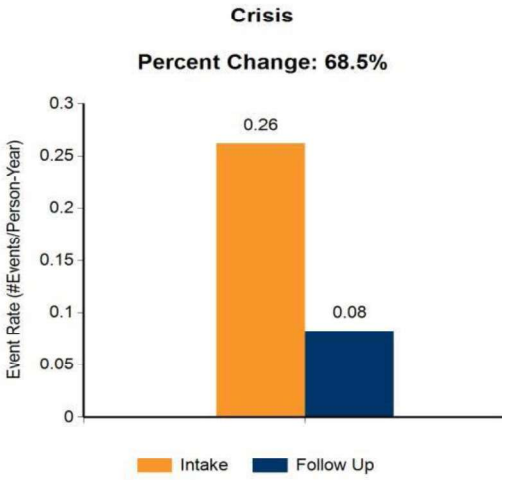

**Diagnosis**

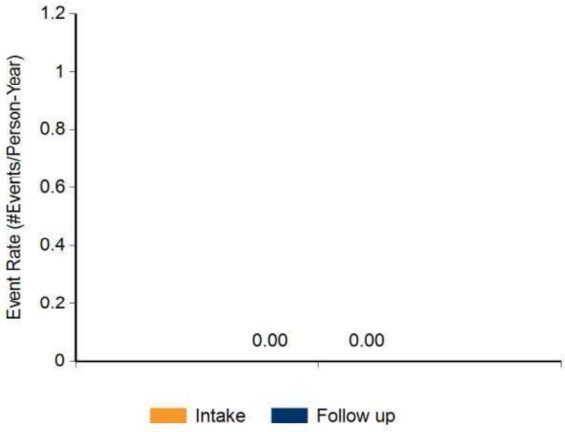


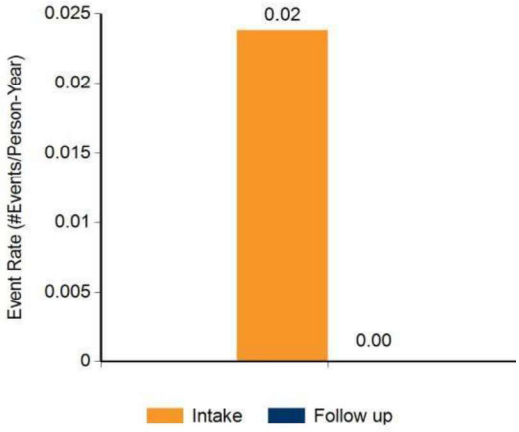
## Outcomes for 33MOFC

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.



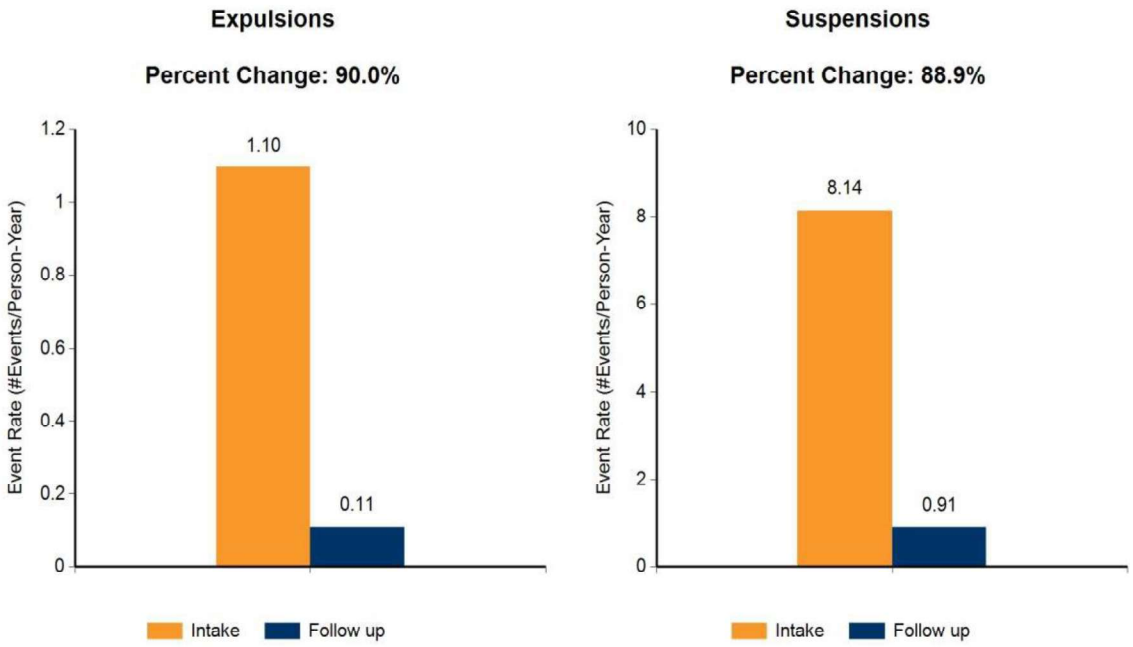



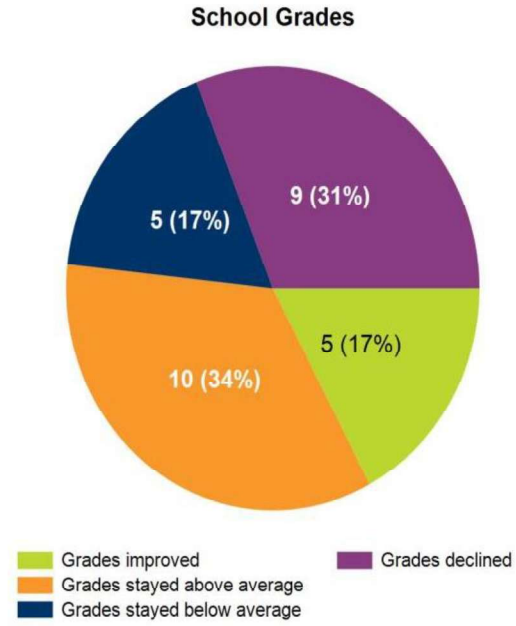
## Outcomes for 33MOFC (cont.)

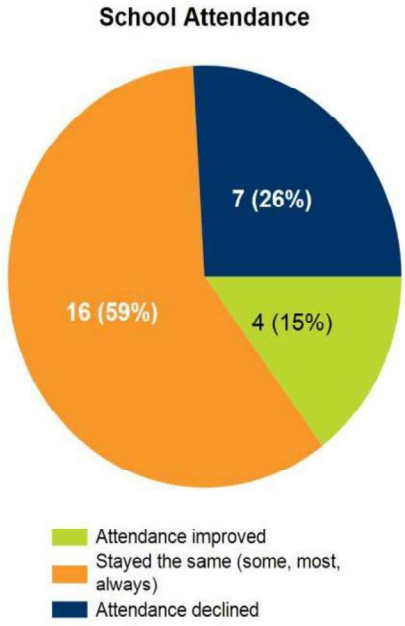
Additional primary outcomes of interest include expulsion and suspension rates, along with school grades and school attendance



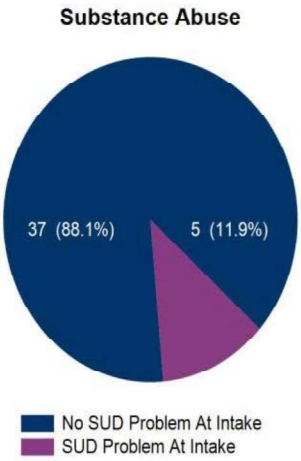


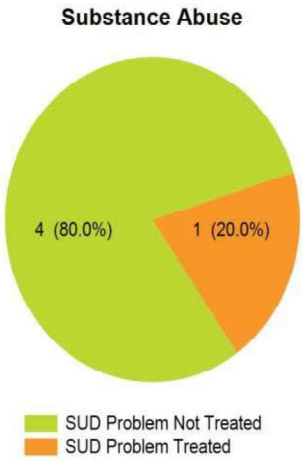




## Outcomes: Substance Use 33MOFC

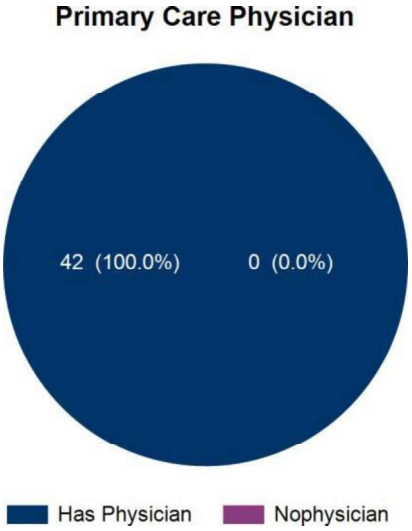



Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (11.9%). The majority of those who had co-occurring MH and SU problems, had been receiving SU treatment services at intake.

An additional 4 consumers not identified at intake were noted to have an SU problem on follow-up and 0.0% of them were reported to be in SU services on follow-up.

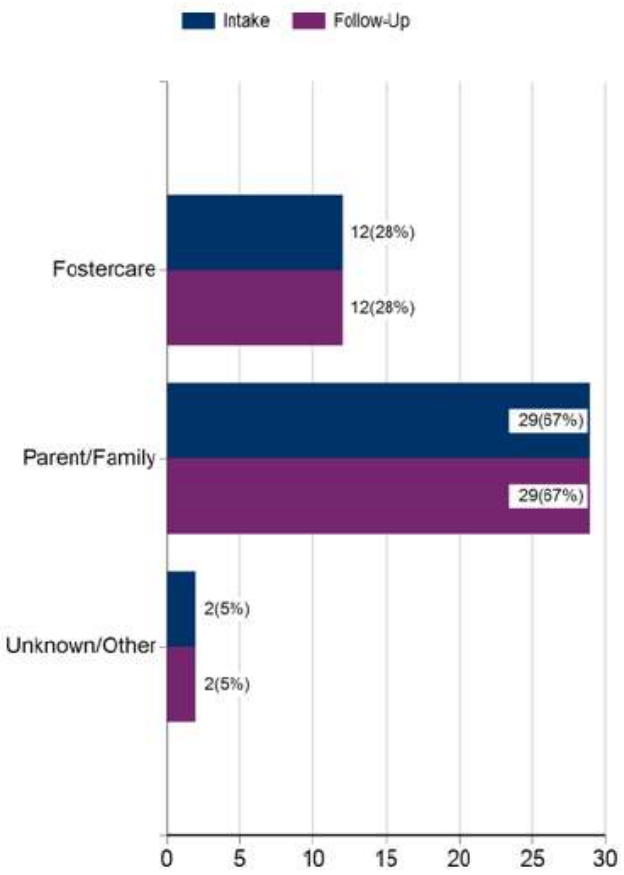
## Outcomes: Primary Care Physician 33MOFC




Intake: Most consumers (0.0%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 0 consumers that did not have a PCP at intake, 0 (0.0%) obtained a PCP while in the program.

## Outcomes: Residential & Discontinuance (33MOFC)




| Discontinuation Reason | Count | % |
|---|---|---|
| Met goals | 9 | 50% |
| Moved out of county/area | 4 | 22% |
| Partner cannot be located | 3 | 17% |
| Partner left program | 2 | 11% |
| **Total** | **18** | **100%** |

## Length of FSP Partnership for: 33MOFC

| Youth Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| >= 1 Year and < 2 Years | 3 | 3 | 6 | 14.29% |
| >= 2 Years and <3 Years | 4 | 3 | 7 | 16.67% |
| >= 90 days and < 1 Year | 5 | 10 | 15 | 35.71% |
| Under 90 days | 5 | 9 | 14 | 33.33% |
| **Total Consumer Enrollments** | **17** | **25** | **42** | |

**Children's FSP demographics and Outcomes for: 33H8FC Served by this reporting unit: 38**

**Demographics**

54% of consumers were male and 46% were female.

59% of consumers were Latinx, 5% of consumers were White and 13% of consumers were Black/African American.

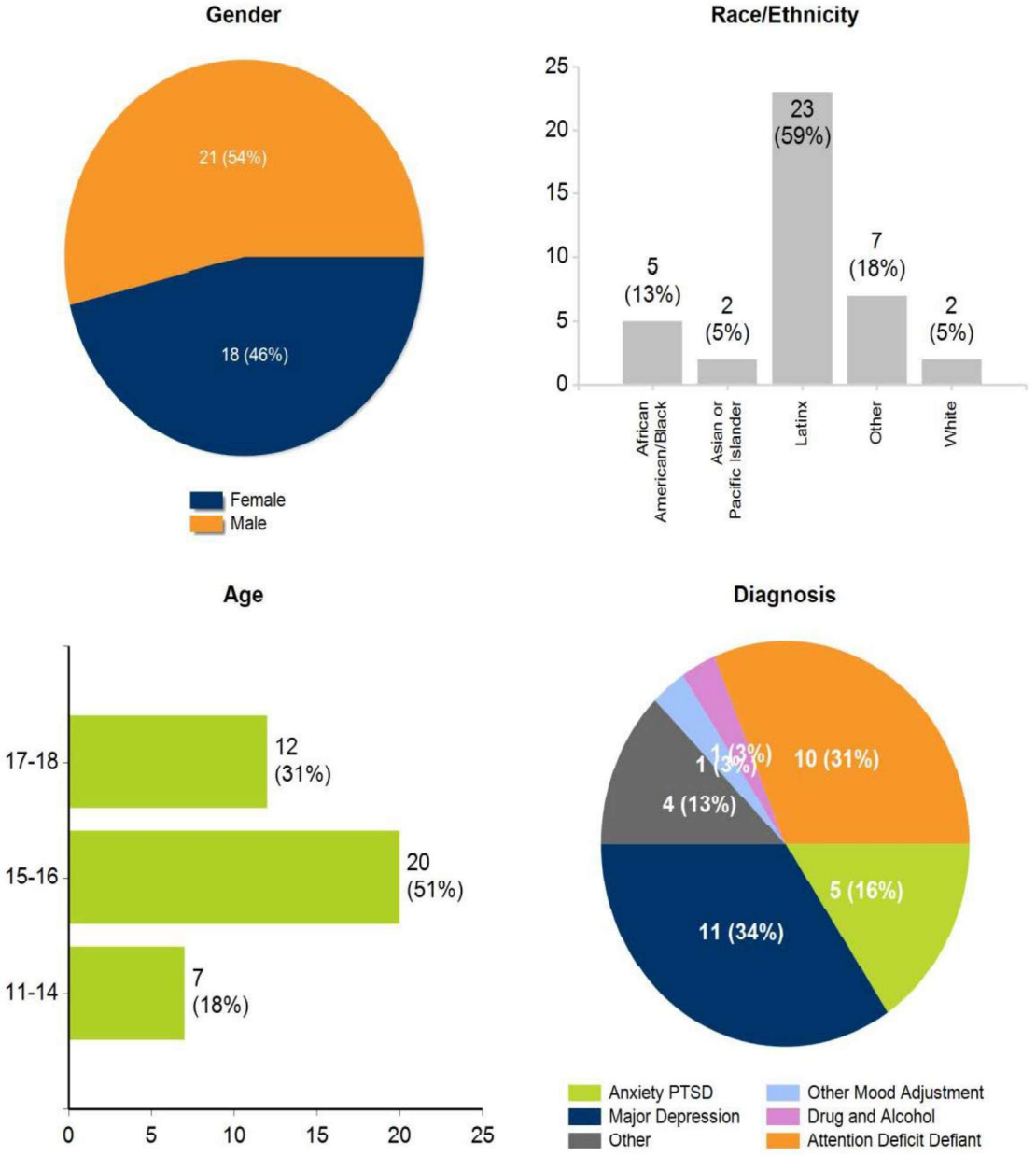
51% of consumers were 15 to 16 years old.

**Service Detail: 33MOFC**

| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 0 (0%) | 0 (0%) | 1 (8%) | 1 (7%) | 3 (25%) | 1 (8%) | 1 (8%) | 2 (15%) | 5 (28%) | 0 (0%) | 1 (5%) | 2 (10%) |
| 2-3 | 6 (33%) | 1 (6%) | 1 (8%) | 5 (36%) | 3 (25%) | 5 (42%) | 2 (17%) | 2 (15%) | 2 (11%) | 3 (19%) | 1 (5%) | 5 (25%) |
| 4-7 | 5 (28%) | 5 (29%) | 5 (38%) | 3 (21%) | 3 (25%) | 3 (25%) | 5 (42%) | 4 (31%) | 7 (39%) | 5 (31%) | 7 (37%) | 5 (25%) |
| 8-13 | 2 (11%) | 4 (24%) | 4 (31%) | 4 (29%) | 3 (25%) | 2 (17%) | 2 (17%) | 5 (38%) | 2 (11%) | 7 (44%) | 7 (37%) | 6 (30%) |
| 14-19 | 4 (22%) | 3 (18%) | 2 (15%) | 1 (7%) | 0 (0%) | 1 (8%) | 1 (8%) | 0 (0%) | 1 (6%) | 1 (6%) | 2 (11%) | 2 (10%) |
| 20-25 | 1 (6%) | 4 (24%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (8%) | 0 (0%) | 1 (6%) | 0 (0%) | 1 (5%) | 0 (0%) |
| Monthly Total | 18 | 17 | 13 | 14 | 12 | 12 | 12 | 13 | 18 | 16 | 19 | 20 |

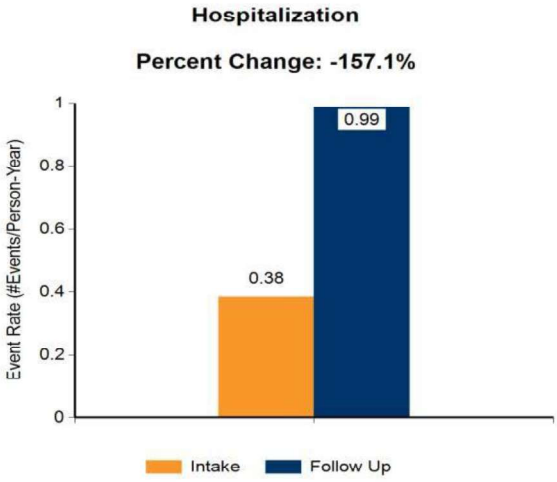
| Type of Service | # of Youth | % of Youth | # of Svcs | Avg. # Svcs |
|---|---|---|---|---|
| Case Management | 12 | 5% | 20 | 1.67 |
| Crisis | 2 | 1% | 2 | 1.00 |
| Family Therapy | 10 | 4% | 13 | 1.30 |
| IHBS | 18 | 8% | 113 | 6.28 |
| Individual Therapy | 30 | 13% | 157 | 5.23 |
| Intensive Care Coordination Services | 35 | 15% | 321 | 9.17 |
| Medication MD Services | 11 | 5% | 23 | 2.09 |
| Medication Therapeutic Services | 28 | 12% | 141 | 5.04 |
| Mental Health Services-Individual | 23 | 10% | 77 | 3.35 |
| Non Face to Face MD | 1 | 0% | 1 | 1.00 |
| Peer MH Engagement | 12 | 5% | 31 | 2.58 |
| Peer MH Therapeutic Activity | 32 | 14% | 281 | 8.78 |
| Peer-IHBS | 15 | 7% | 67 | 4.47 |
| Psychiatric Assessment | 1 | 0% | 1 | 1.00 |

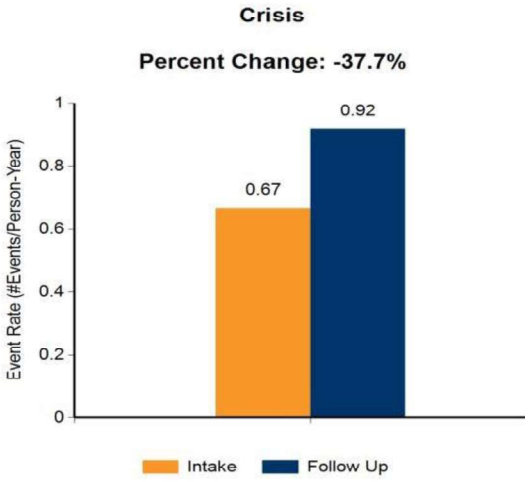
## Outcomes for 33H8FC (cont.)

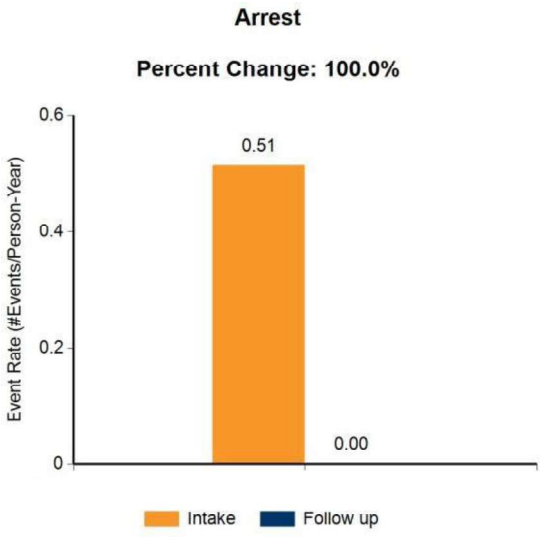


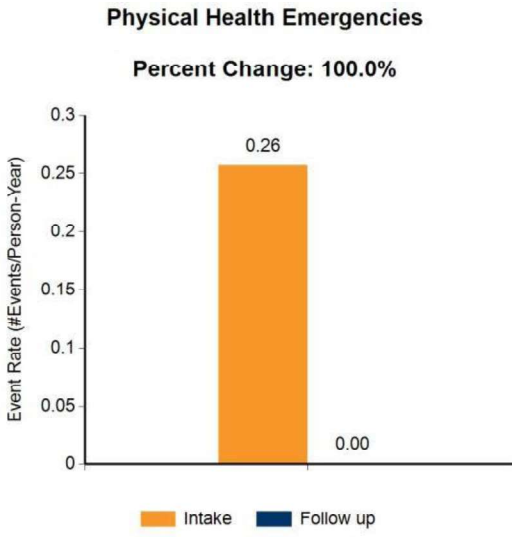

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

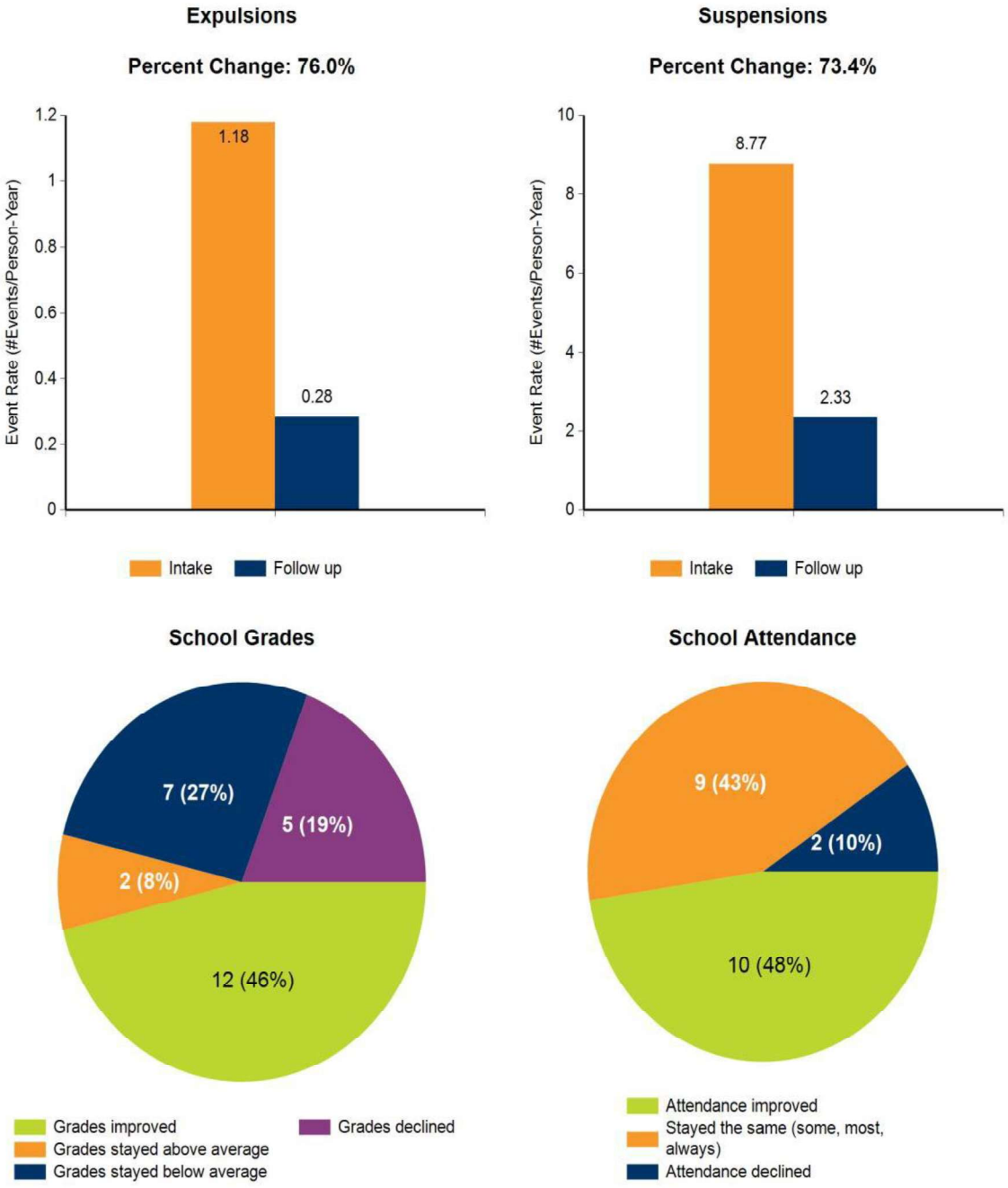
Additional primary outcomes of interest include expulsion and suspension rates, as well as school grades and attendance.



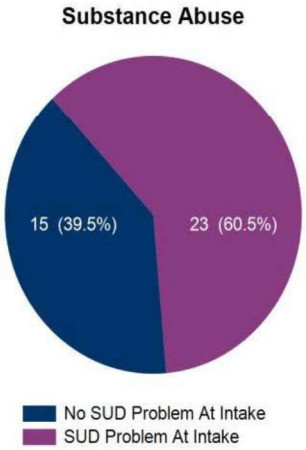



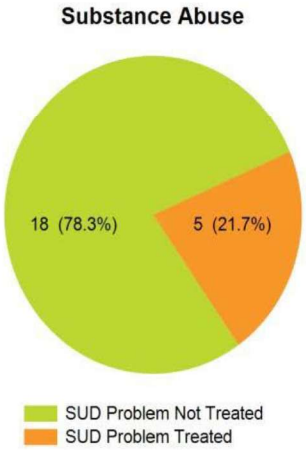






Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (60.5%). The majority of those who had co-occurring MH and SU problems, had been receiving SU treatment services at intake.

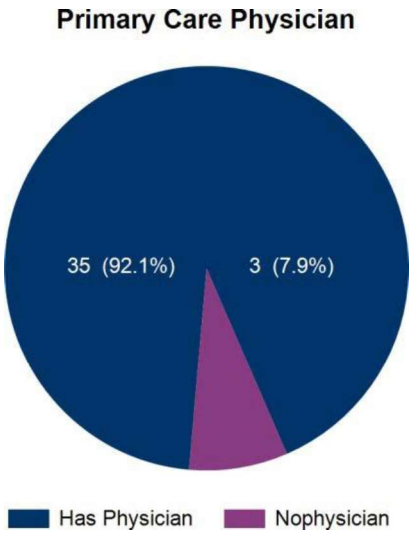
## Outcomes: Substance Use 33H8FC




An additional 3 consumers not identified at intake were noted to have an SU problem on follow-up and 67.0% of them were reported to be in SU services on follow-up.

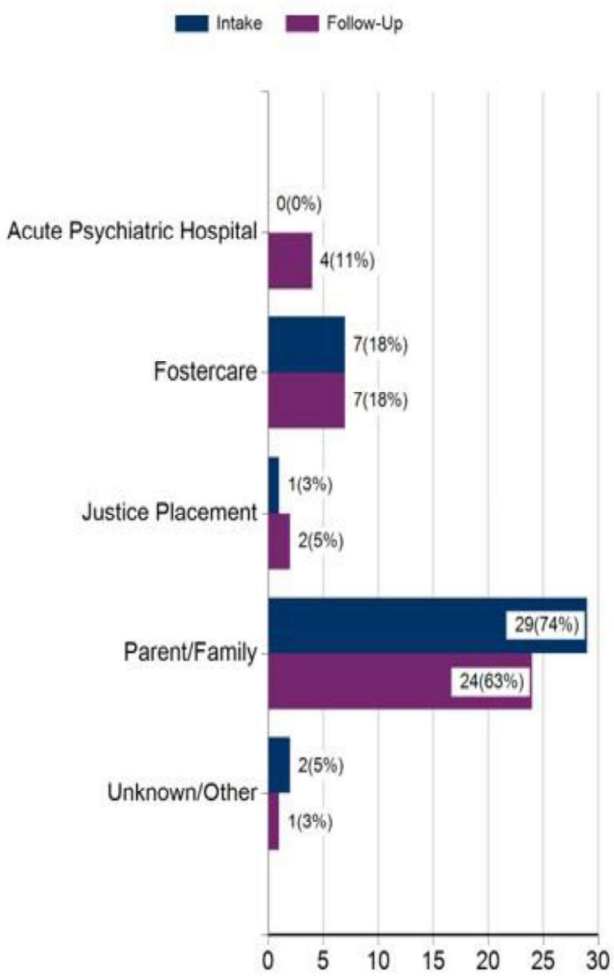
## Outcomes: Primary Care Physician 33H8FC




Intake: Most consumers (7.9%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 3 consumers that did not have a PCP at intake, 1 (33.0%) obtained a PCP while in the program.

## Outcomes: Residential & Discontinuance (33H8FC)




| Discontinuation Reason | Count | % |
|---|---|---|
| Met goals | 10 | 40% |
| Moved out of county/area | 1 | 4% |
| Needs residential care | 2 | 8% |
| Other | 3 | 12% |
| Partner cannot be located | 1 | 4% |
| Partner left program | 5 | 20% |
| Target criteria not met | 3 | 12% |
| **Total** | **25** | **100%** |

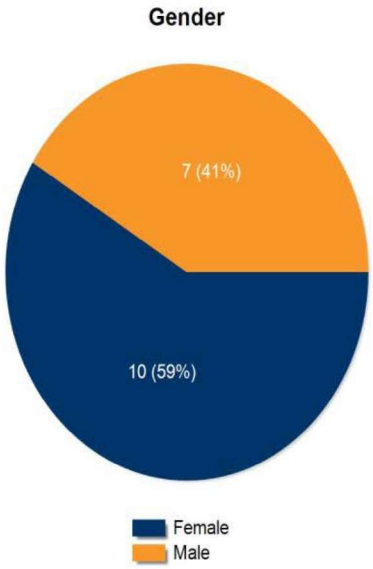
## Length of FSP Partnership for: 33H8FC

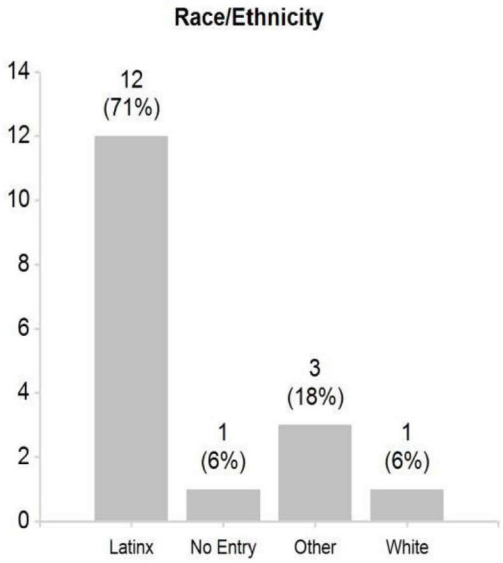
| Youth Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| >= 90 days and < 1 Year | 19 | 6 | 25 | 64.10% |
| Under 90 days | 10 | 4 | 14 | 35.90% |
| **Total Consumer Enrollments** | **29** | **10** | **39** | |

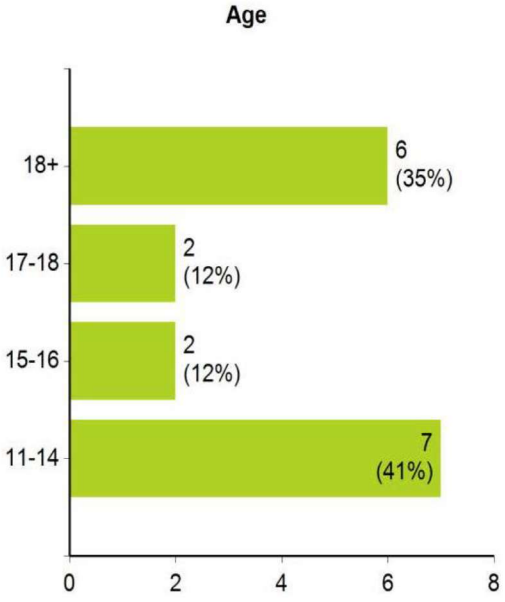
**Children's FSP demographics and Outcomes for:**
**33MOFEP Served by this reporting unit: 17**

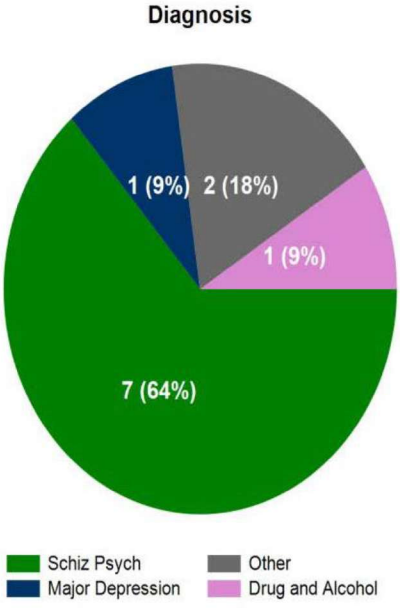
**Demographics**

41% of consumers were male and 59% were female.




71% of consumers were Latinx, 6% of consumers were White and 0% of consumers were Black/African American.

12% of consumers were 15 to 16 years old.

## Outcomes for 33MOFEP

### Service Detail: 33H8FC

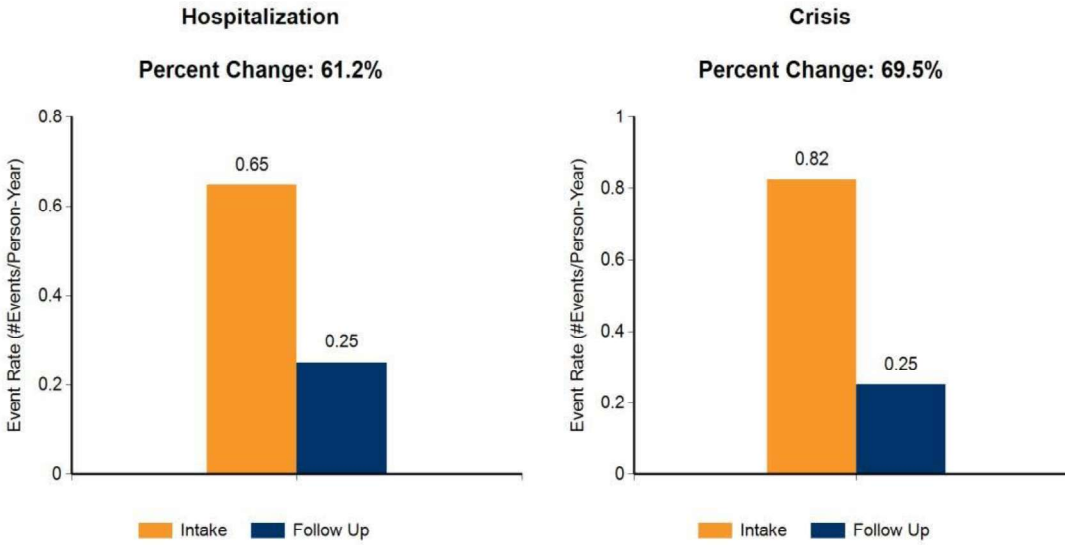
| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 1 (7%) | 2 (13%) | 0 (0%) | 1 (7%) | 0 (0%) | 0 (0%) | 0 (0%) | 2 (13%) | 0 (0%) | 1 (7%) | 0 (0%) | 1 (8%) |
| 2-3 | 1 (7%) | 1 (6%) | 2 (15%) | 2 (13%) | 0 (0%) | 0 (0%) | 3 (20%) | 2 (13%) | 2 (14%) | 2 (13%) | 0 (0%) | 0 (0%) |
| 4-7 | 0 (0%) | 0 (0%) | 1 (8%) | 1 (7%) | 1 (7%) | 3 (20%) | 0 (0%) | 0 (0%) | 3 (21%) | 2 (13%) | 1 (8%) | 2 (15%) |
| 8-13 | 4 (27%) | 5 (31%) | 6 (46%) | 5 (33%) | 7 (50%) | 8 (53%) | 4 (27%) | 7 (44%) | 1 (7%) | 0 (0%) | 2 (15%) | 2 (15%) |
| 14-19 | 1 (7%) | 2 (13%) | 4 (31%) | 4 (27%) | 5 (36%) | 2 (13%) | 1 (7%) | 0 (0%) | 1 (7%) | 2 (13%) | 2 (15%) | 4 (31%) |
| 20-25 | 5 (33%) | 2 (13%) | 0 (0%) | 1 (7%) | 1 (7%) | 2 (13%) | 2 (13%) | 3 (19%) | 3 (21%) | 3 (20%) | 5 (38%) | 3 (23%) |
| 26-31 | 2 (13%) | 2 (13%) | 0 (0%) | 1 (7%) | 0 (0%) | 0 (0%) | 3 (20%) | 0 (0%) | 2 (14%) | 1 (7%) | 2 (15%) | 0 (0%) |
| 32+ | 1 (7%) | 2 (13%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 2 (13%) | 2 (13%) | 2 (14%) | 4 (27%) | 1 (8%) | 1 (8%) |
| Monthly Total | 15 | 16 | 13 | 15 | 14 | 15 | 15 | 16 | 14 | 15 | 13 | 13 |

| Type of Service | # of Youth | % of Youth | # of Svcs | Avg. # Svcs |
|---|---|---|---|---|
| Assessment Services | 16 | 7% | 17 | 1.06 |
| Case Management | 24 | 11% | 81 | 3.38 |
| Collateral Services | 3 | 1% | 9 | 3.00 |
| Crisis | 8 | 4% | 24 | 3.00 |
| Family Therapy | 33 | 15% | 312 | 9.45 |
| IHBS | 24 | 11% | 76 | 3.17 |
| Individual Therapy | 35 | 16% | 485 | 13.86 |
| Intensive Care Coordination Services | 38 | 18% | 1,609 | 42.34 |
| Mental Health Services-Individual | 33 | 15% | 146 | 4.42 |
| Non Family Collateral | 2 | 1% | 4 | 2.00 |

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

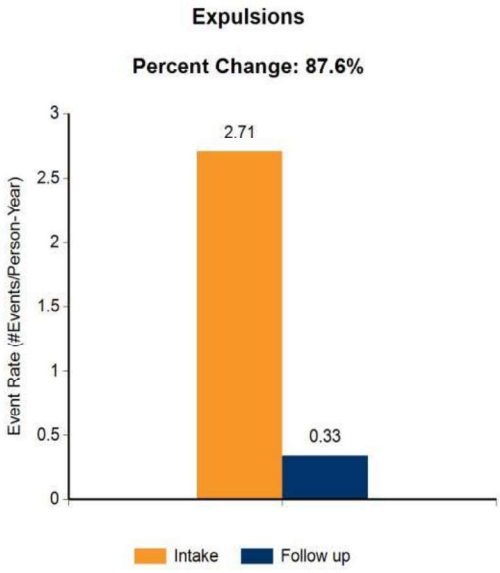
## Outcomes for 33MOFEP (cont.)

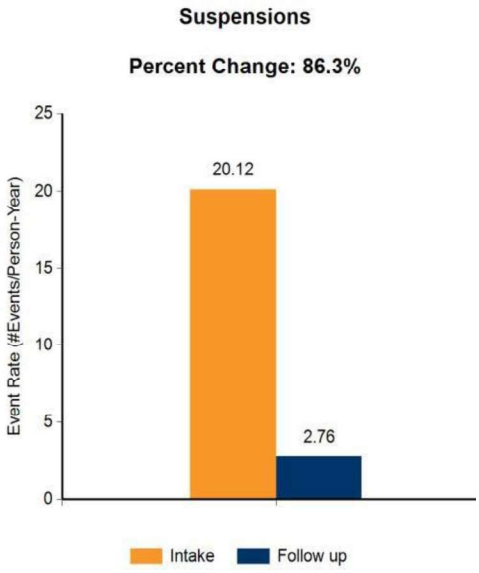
Additional primary outcomes of interest include expulsion and suspension rates, along with school grades and school attendance.



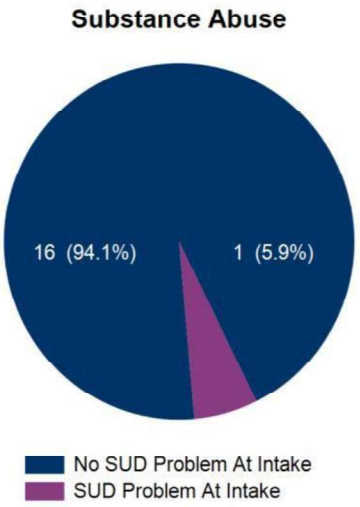


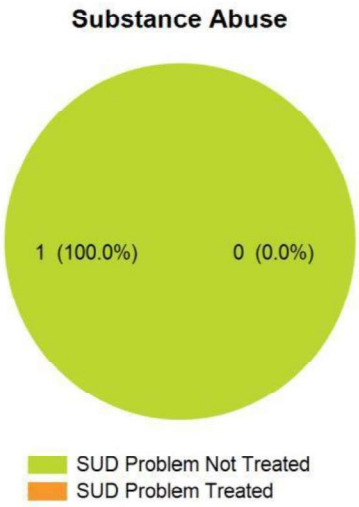




## Outcomes: Substance Use 33MOFEP

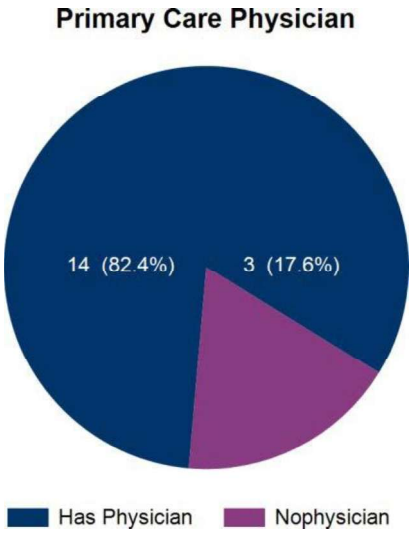



Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (5.9%). The majority of those who had co-occurring MH and SU problems had been receiving SU treatment services at intake.

An additional 1 consumer not identified at intake was noted to have an SU problem on follow-up, and 100.0% of them were reported to be in SU services on follow-up.

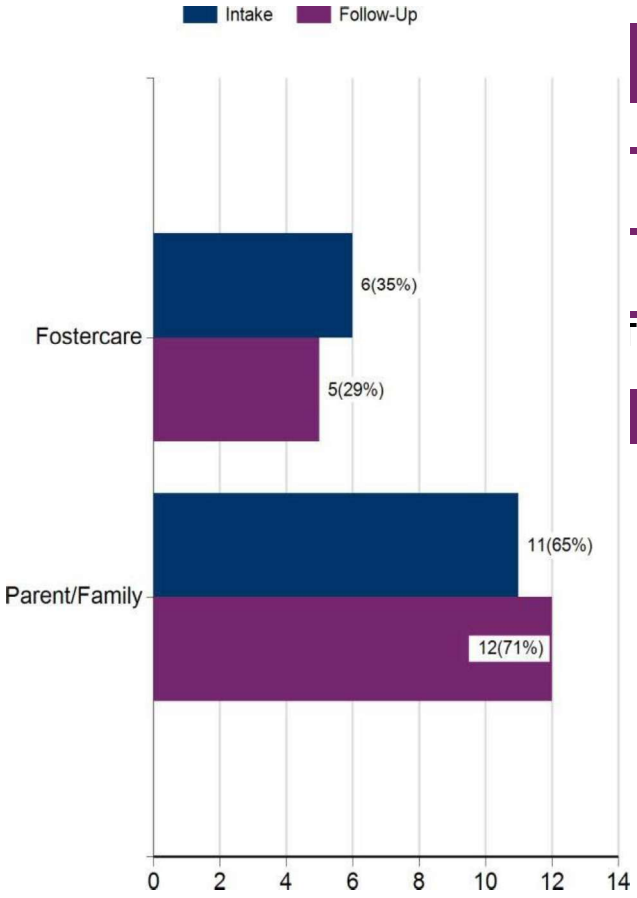
## Outcomes: Primary Care Physician 33MOFEP




Intake: Most consumers (17.6%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 3 consumers that did not have a PCP at intake, 2 (67.0%) obtained a PCP while in the program.

## Outcomes: Residential & Discontinuance (33MOFEP)




| Discontinuation Reason | Count | % |
|---|---|---|
| Met goals | 1 | 17% |
| Moved out of county/area | 2 | 33% |
| Partner left program | 2 | 33% |
| Target criteria not met | 1 | 17% |
| **Total** | **6** | **100%** |

## Length of FSP Partnership for: 33MOFEP

| Youth Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| >= 1 Year and < 2 Years | 2 | 3 | 5 | 29.41% |
| >= 90 days and < 1 Year | 4 | 4 | 8 | 47.06% |
| Under 90 days | 3 | 1 | 4 | 23.53% |
| **Total Consumer Enrollments** | **9** | **8** | **17** | |

## Service Detail:33MOFEP

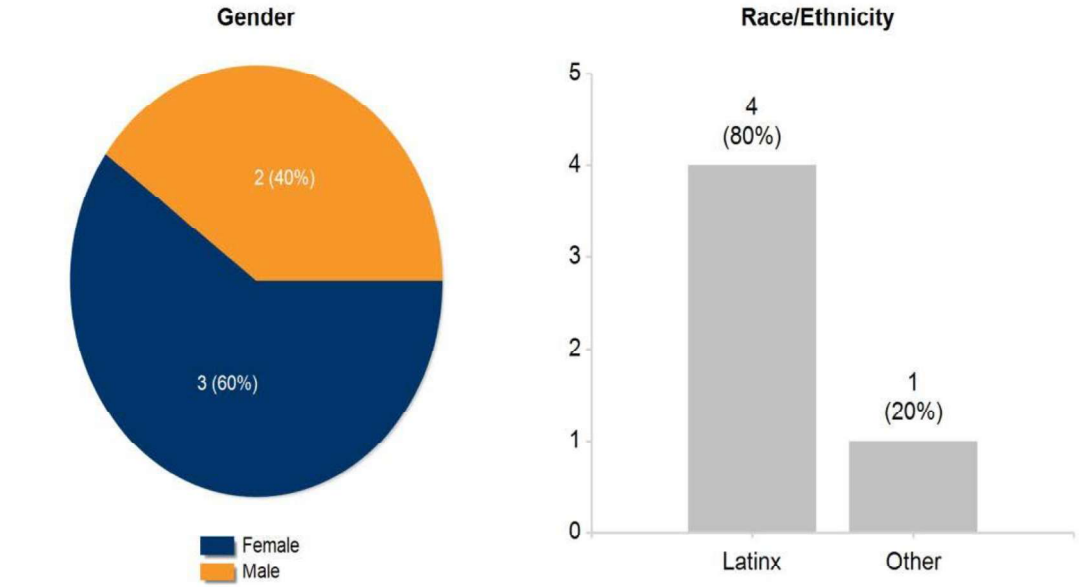
| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 0 (0%) | 0 (0%) | 1 (9%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (8%) | 2 (17%) | 0 (0%) | 0 (0%) | 1 (8%) | 1 (9%) |
| 2-3 | 2 (22%) | 0 (0%) | 1 (9%) | 1 (8%) | 1 (9%) | 1 (8%) | 1 (8%) | 0 (0%) | 2 (18%) | 1 (9%) | 1 (8%) | 1 (9%) |
| 4-7 | 1 (11%) | 2 (20%) | 0 (0%) | 3 (25%) | 2 (18%) | 2 (17%) | 1 (8%) | 2 (17%) | 2 (18%) | 2 (18%) | 1 (8%) | 2 (18%) |
| 8-13 | 0 (0%) | 3 (30%) | 3 (27%) | 3 (25%) | 3 (27%) | 3 (25%) | 6 (50%) | 4 (33%) | 4 (36%) | 4 (36%) | 2 (17%) | 3 (27%) |
| 14-19 | 2 (22%) | 1 (10%) | 4 (36%) | 2 (17%) | 1 (9%) | 4 (33%) | 1 (8%) | 2 (17%) | 2 (18%) | 3 (27%) | 4 (33%) | 4 (36%) |
| 20-25 | 4 (44%) | 2 (20%) | 2 (18%) | 3 (25%) | 3 (27%) | 1 (8%) | 2 (17%) | 1 (8%) | 1 (9%) | 1 (9%) | 3 (25%) | 0 (0%) |
| 26-31 | 0 (0%) | 2 (20%) | 0 (0%) | 0 (0%) | 1 (9%) | 1 (8%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| 32+ | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (8%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| Monthly Total | 9 | 10 | 11 | 12 | 11 | 12 | 12 | 12 | 11 | 11 | 12 | 11 |

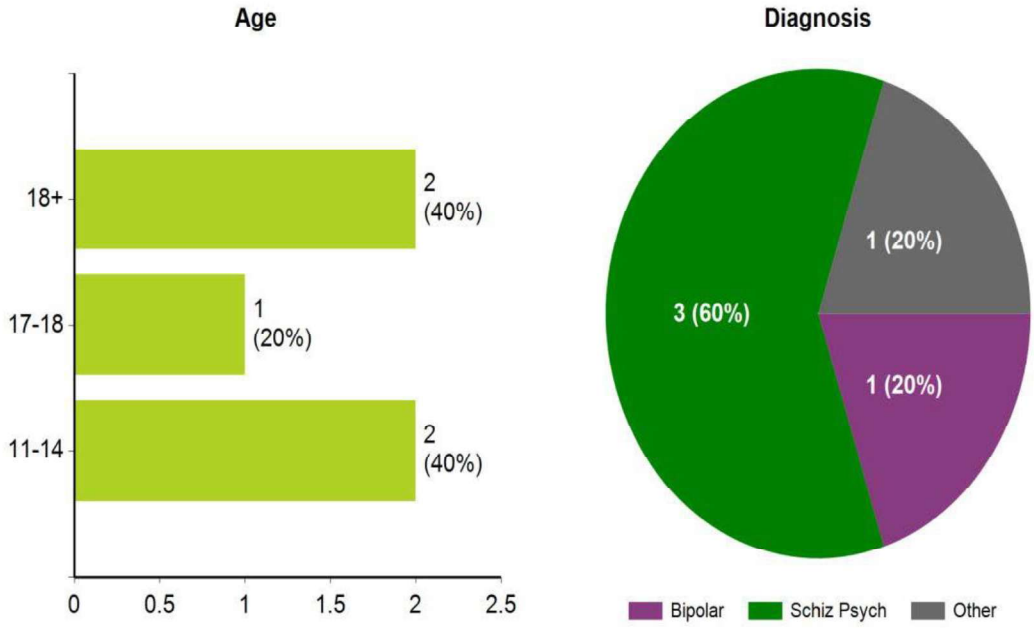
| Type of Service | # of Youth | % of Youth | # of Svcs | Avg. # Svcs |
|---|---|---|---|---|
| Case Management | 15 | 9% | 129 | 8.60 |
| Client Supportive Services | 1 | 1% | 1 | 1.00 |
| Crisis | 2 | 1% | 4 | 2.00 |
| Family Therapy | 9 | 5% | 33 | 3.67 |
| IHBS | 13 | 8% | 103 | 7.92 |
| Individual Therapy | 14 | 8% | 173 | 12.36 |
| Intensive Care Coordination Services | 16 | 9% | 313 | 19.56 |
| Medication MD Services | 14 | 8% | 93 | 6.64 |
| Medication Therapeutic Services | 12 | 7% | 220 | 18.33 |
| Mental Health Services-Group | 5 | 3% | 14 | 2.80 |
| Mental Health Services-Individual | 13 | 8% | 61 | 4.69 |
| Non Face to Face MD | 12 | 7% | 39 | 3.25 |
| Peer MH Education Groups | 8 | 5% | 33 | 4.13 |
| Peer MH Engagement | 5 | 3% | 7 | 1.40 |
| Peer MH Therapeutic Activity | 15 | 9% | 289 | 19.27 |
| Peer-IHBS | 14 | 8% | 168 | 12.00 |
| Psychiatric Assessment | 5 | 3% | 5 | 1.00 |

**Children's FSP demographics and Outcomes for: 33OPFEP**
**Served by this reporting unit: 5 Enrollment: 5**

## Demographics

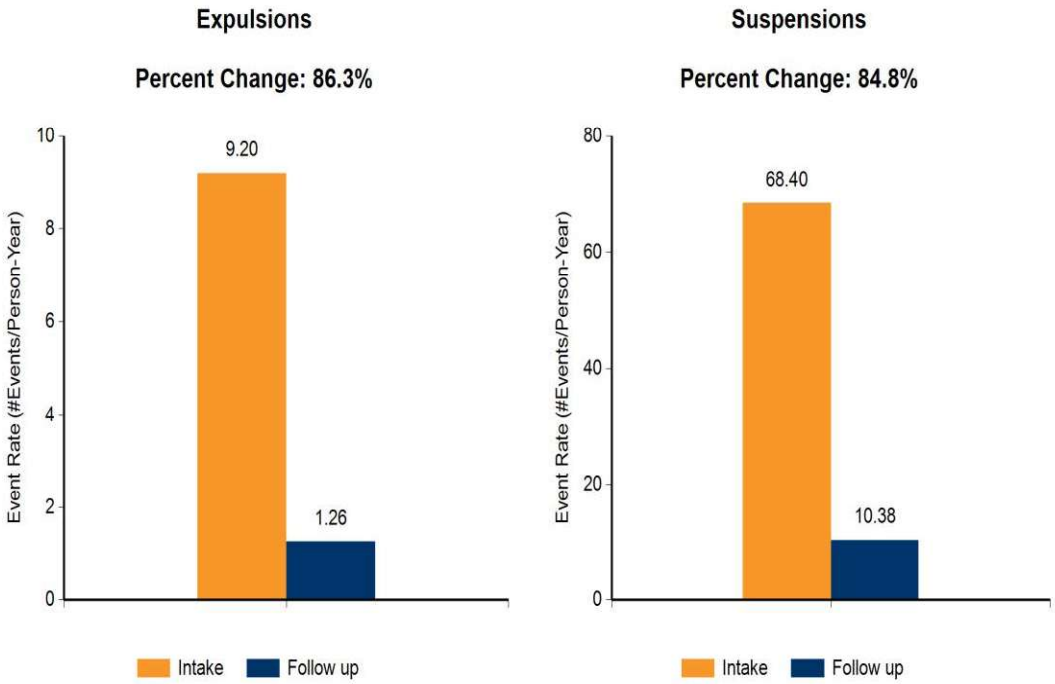
40% of consumers identified as male, while 60% identified as female. 80% of consumers were Latinx, with 0% being White and 0% being Black/African American. Additionally, 0% of consumers were aged 15 to 16 years.



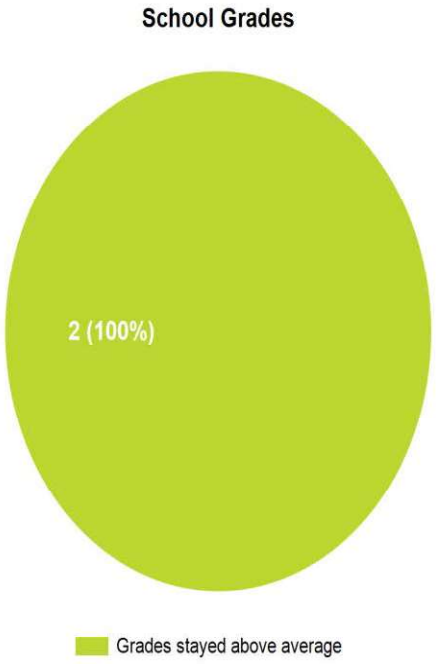
## Outcomes for 33OPFEP

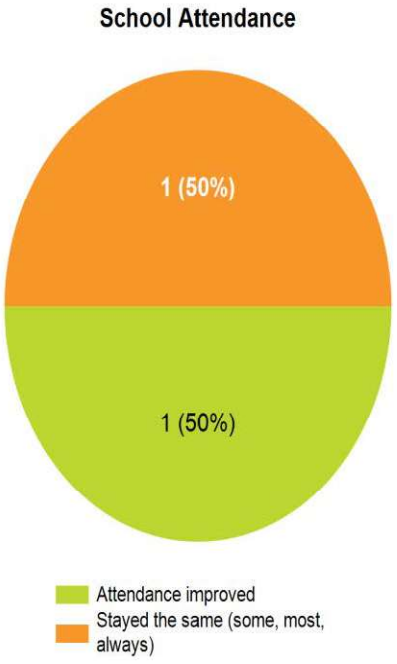
Additional primary outcomes of interest include explusion and suspension rates, along with school grades and school attendance.



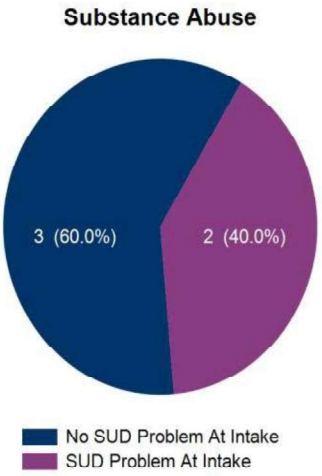


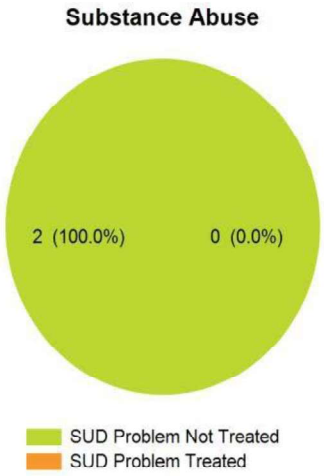




## Outcomes: Substance Use 33OPFEP

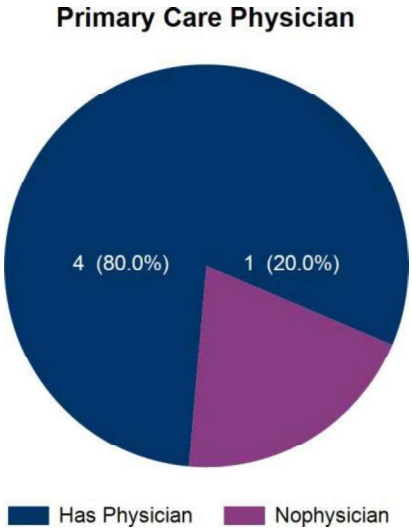



Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (40.0%). The majority of those who had co-occurring MH and SU problems, had been receiving SU treatment services at intake.

An additional 1 consumers not identified at intake were noted to have an SU problem on follow-up and 0.0% of them were reported to be in SU services on follow-up.

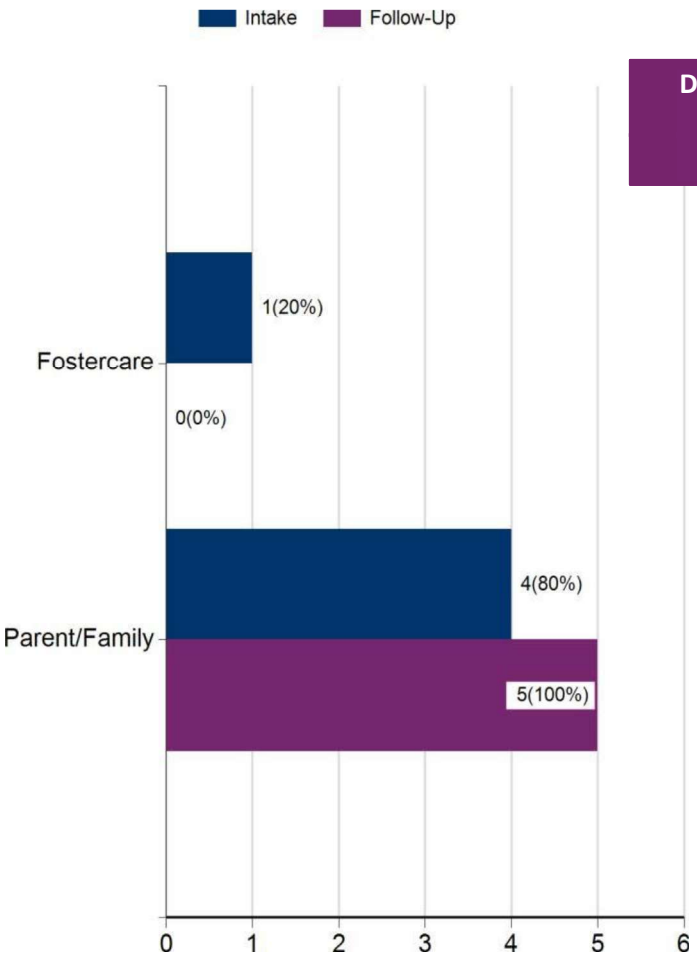
## Outcomes: Primary Care Physician 33OPFEP




Intake: Most consumers (20.0%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 1 consumer that did not have a PCP at intake, 1 (100.0%) obtained a PCP while in the program.

## Outcomes: Residential & Discontinuance (33OPFEP)




| Discontinuation Reason | Count | % |
|---|---|---|
| Total | 0 | 100% |

## Length of FSP Partnership for: 33OPFEP

| Youth Time in Partnership | Open | All Consumers | % of Total |
|---|---|---|---|
| >= 90 days and < 1 Year | 4 | 4 | 80.00% |
| Under 90 days | 1 | 1 | 20.00% |
| **Total Consumer Enrollments** | **5** | **5** | |

## Service Detail:33OPFEP

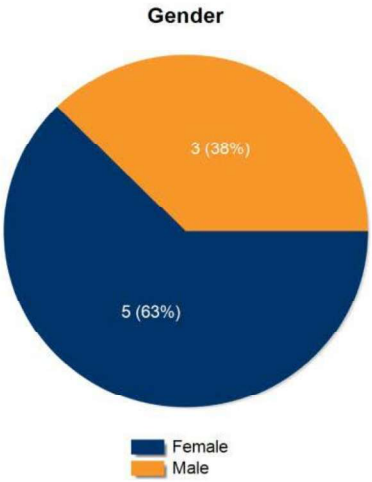
| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 1 (50%) | 0 (0%) | 0 (0%) | 2 (50%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| 2-3 | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (20%) |
| 4-7 | 1 (50%) | 1 (50%) | 0 (0%) | 0 (0%) | 1 (33%) | 1 (25%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (20%) | 0 (0%) |
| 8-13 | 0 (0%) | 1 (50%) | 1 (50%) | 0 (0%) | 0 (0%) | 2 (50%) | 1 (25%) | 1 (25%) | 1 (25%) | 0 (0%) | 1 (20%) | 4 (80%) |
| 14-19 | 0 (0%) | 0 (0%) | 1 (50%) | 1 (25%) | 1 (33%) | 1 (25%) | 1 (25%) | 1 (25%) | 1 (25%) | 1 (25%) | 3 (60%) | 0 (0%) |
| 20-25 | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (33%) | 0 (0%) | 2 (50%) | 0 (0%) | 2 (50%) | 1 (25%) | 0 (0%) | 0 (0%) |
| 26-31 | 0 (0%) | 0 (0%) | 0 (0%) | 1 (25%) | 0 (0%) | 0 (0%) | 0 (0%) | 2 (50%) | 0 (0%) | 1 (25%) | 0 (0%) | 0 (0%) |
| 32+ | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (25%) | 0 (0%) | 0 (0%) |
| Monthly Total | 2 | 2 | 2 | 4 | 3 | 4 | 4 | 4 | 4 | 4 | 5 | 5 |

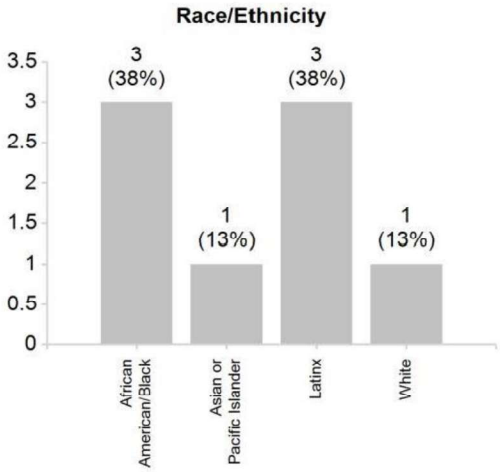
| Type of Service | # of Youth | % of Youth | # of Svcs | Avg. # Svcs |
|---|---|---|---|---|
| Case Management | 5 | 10% | 85 | 17.00 |
| Crisis | 1 | 2% | 1 | 1.00 |
| Family Therapy | 1 | 2% | 3 | 3.00 |
| IHBS | 4 | 8% | 28 | 7.00 |
| Individual Therapy | 4 | 8% | 52 | 13.00 |
| Intensive Care Coordination Services | 4 | 8% | 75 | 18.75 |
| Medication MD Services | 5 | 10% | 36 | 7.20 |
| Medication Therapeutic Services | 5 | 10% | 80 | 16.00 |
| Mental Health Services-Individual | 2 | 4% | 4 | 2.00 |
| Non Face to Face MD | 4 | 8% | 7 | 1.75 |
| Peer MH Education Groups | 2 | 4% | 2 | 1.00 |
| Peer MH Engagement | 2 | 4% | 3 | 1.50 |
| Peer MH Therapeutic Activity | 5 | 10% | 136 | 27.20 |
| Peer-IHBS | 4 | 8% | 99 | 24.75 |
| Psychiatric Assessment | 1 | 2% | 1 | 1.00 |

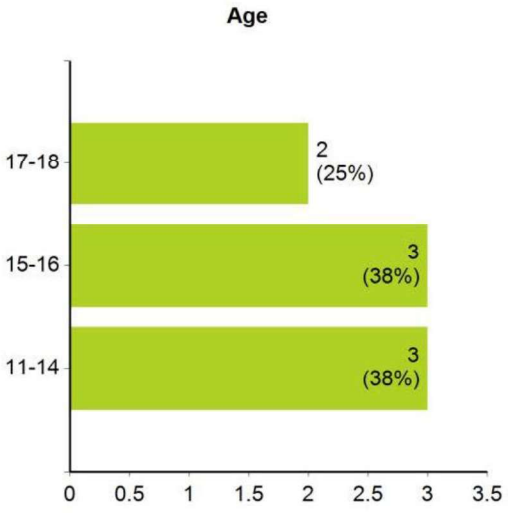
## Children's FSP demographics and Outcomes for: 33A2FC Served by this reporting unit: 8

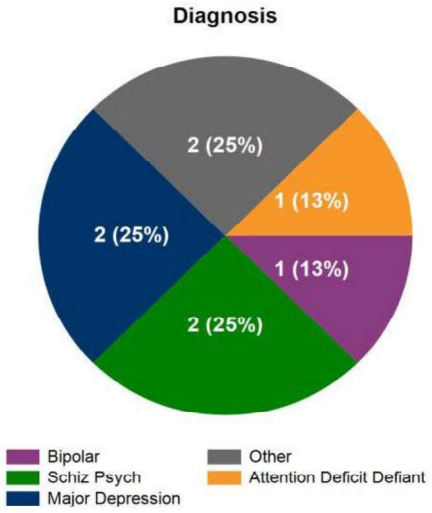
### Demographics

38% of consumers were male and 63% were female.
38% of consumers were Latinx, 13% of consumers were White and 38% of consumers were Black/African American.
38% of consumers were 15 to 16 years old.



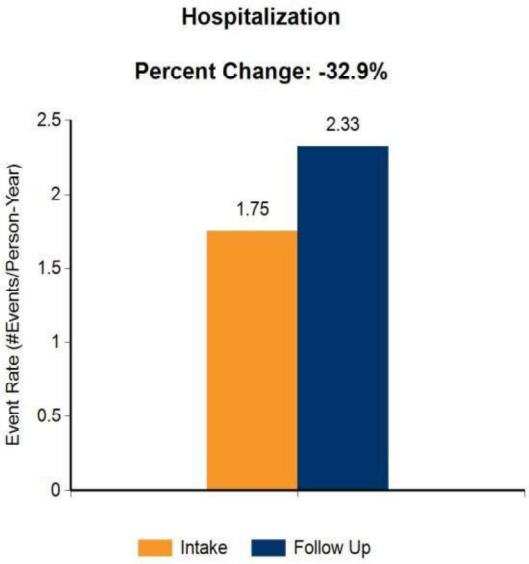



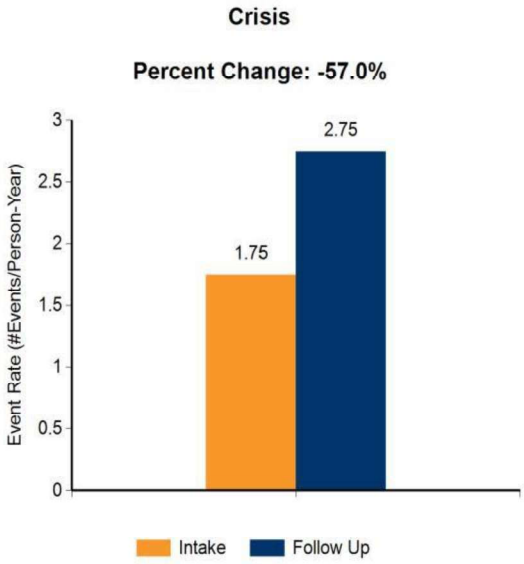



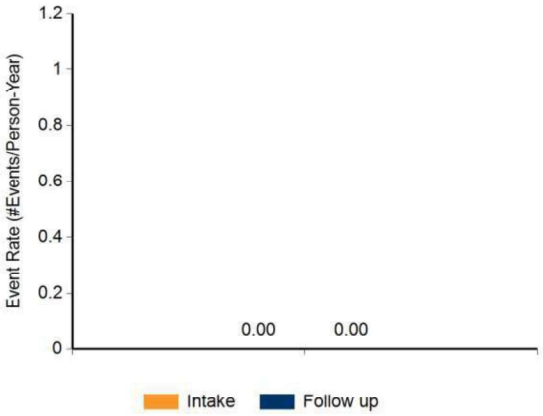



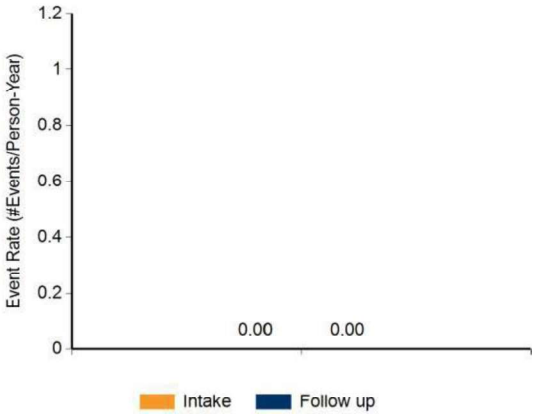
## Outcomes for 33A2FC

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.



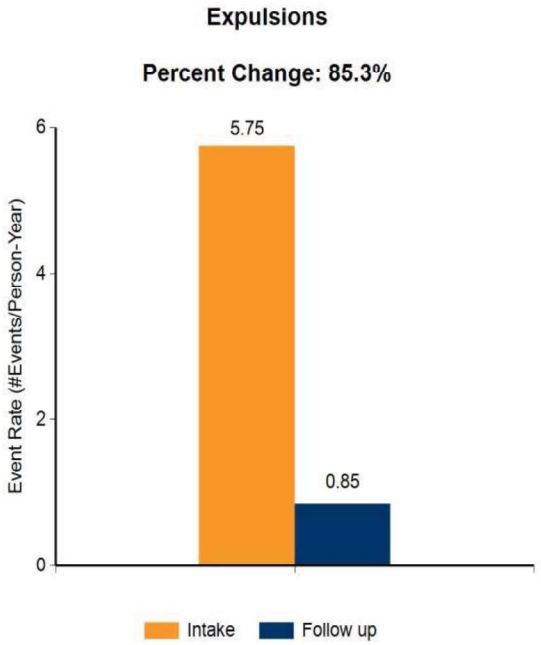



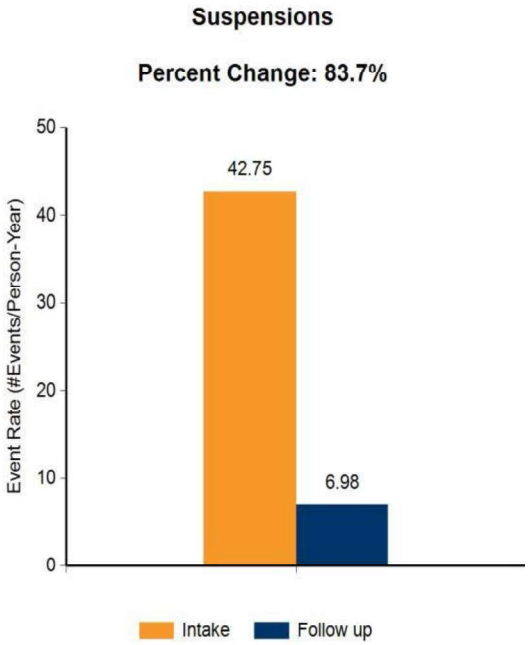



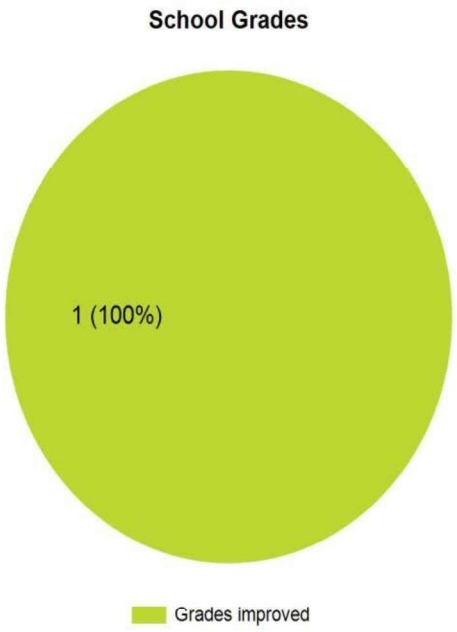



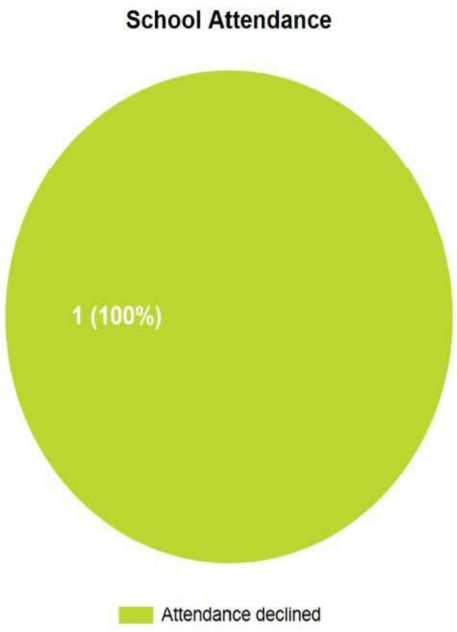
## Outcomes for 33A2FC (cont.)

Additional primary outcomes of interest include expulsion and suspension rates, as well as school grades and attendance.

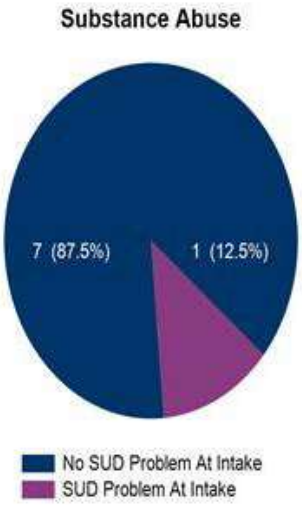


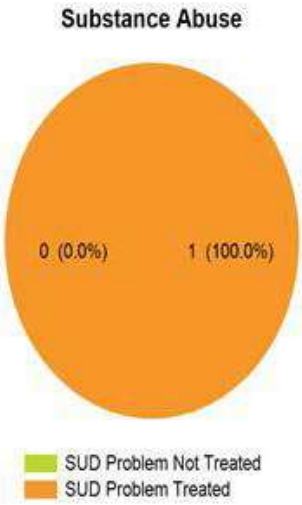



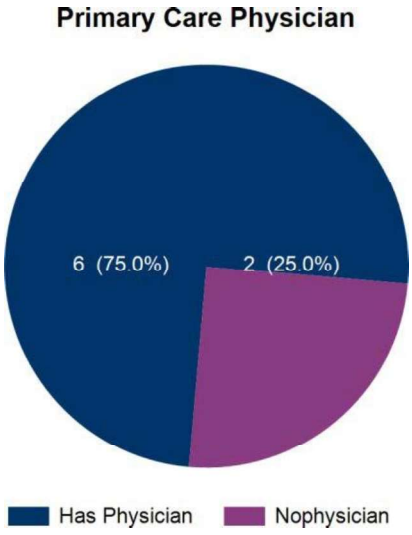
## Outcomes: Residential & Discontinuance (33A2FC)



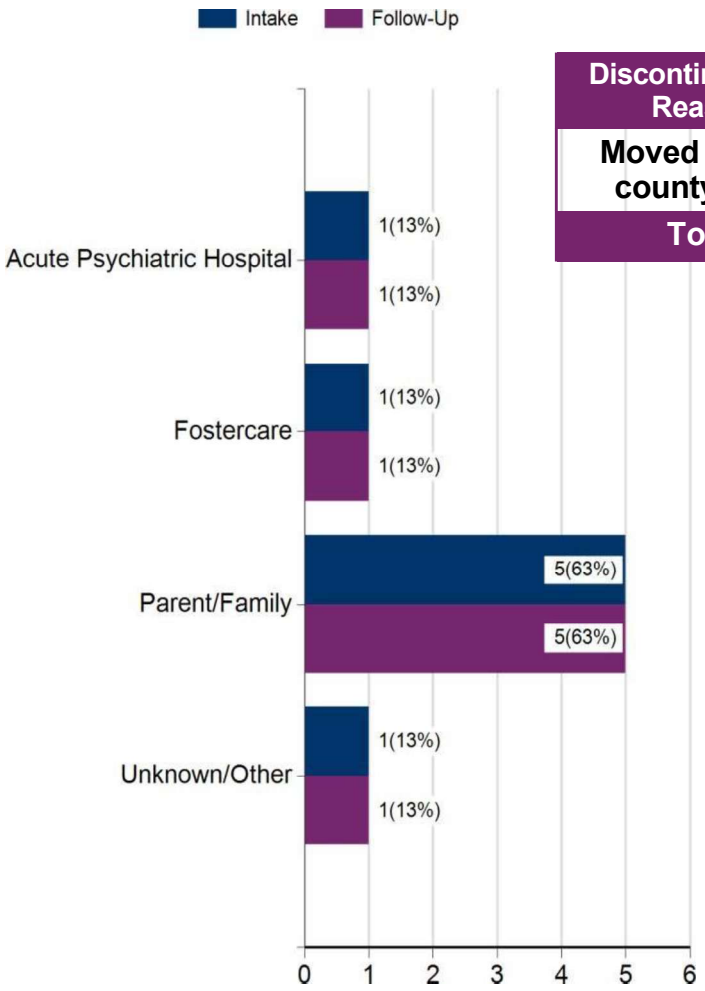

Intake: A considerable proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) issues (12.5%). Most of those with co-occurring MH and SU problems had been receiving SU treatment services at intake. An additional 0 consumers who were not identified at intake were found to have an SU problem during follow-up, and 0.0% of them were reported to be receiving SU services at that time.

## Outcomes: Primary Care Physician 33A2FC




Intake: Most consumers (25.0%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 2 consumers that did not have a PCP at intake, 1 (50.0%) obtained a PCP while in the program.




| Discontinuation Reason | Count | % |
|---|---|---|
| **Moved out of county/area** | 2 | 100% |
| **Total** | **2** | **100%** |

**Length of FSP Partnership for: 33A2FC**

| Youth Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| >= 1 Year and < 2 Years | 0 | 1 | 1 | 12.50% |
| >= 90 days and < 1 Year | 1 | 4 | 5 | 62.50% |
| Under 90 days | 1 | 1 | 2 | 25.00% |
| **Total Consumer Enrollments** | **2** | **6** | **8** | |

## Service Detail: 33A2FC

| Service Frequencies | Aug | Sep | Oct | Jan | Feb | Mar | May | Jun |
|---|---|---|---|---|---|---|---|---|
| 0-1 | 1 (100%) | 2 (100%) | 1 (100%) | 1 (100%) | 1 (50%) | 1 (50%) | 0 (0%) | 0 (0%) |
| 2-3 | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (50%) | 1 (50%) | 3 (100%) | 0 (0%) |
| 4-7 | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (100%) |
| Monthly Total | 1 | 2 | 1 | 1 | 2 | 2 | 3 | 1 |

| Type of Service | # of Youth | % of Youth | # of Svcs | Avg. # Svcs |
|---|---|---|---|---|
| Assessment Services | 1 | 6% | 1 | 1.00 |
| Case Management | 2 | 13% | 4 | 2.00 |
| Intensive Care Coordination Services | 1 | 6% | 1 | 1.00 |
| Medication MD Services | 3 | 19% | 7 | 2.33 |
| Medication Therapeutic Services | 2 | 13% | 2 | 1.00 |
| Mental Health Services-Individual | 2 | 13% | 2 | 1.00 |
| Non Face to Face MD | 1 | 6% | 1 | 1.00 |
| Peer MH Engagement | 1 | 6% | 1 | 1.00 |
| Peer MH Therapeutic Activity | 1 | 6% | 1 | 1.00 |
| Psychiatric Assessment | 2 | 13% | 2 | 1.00 |

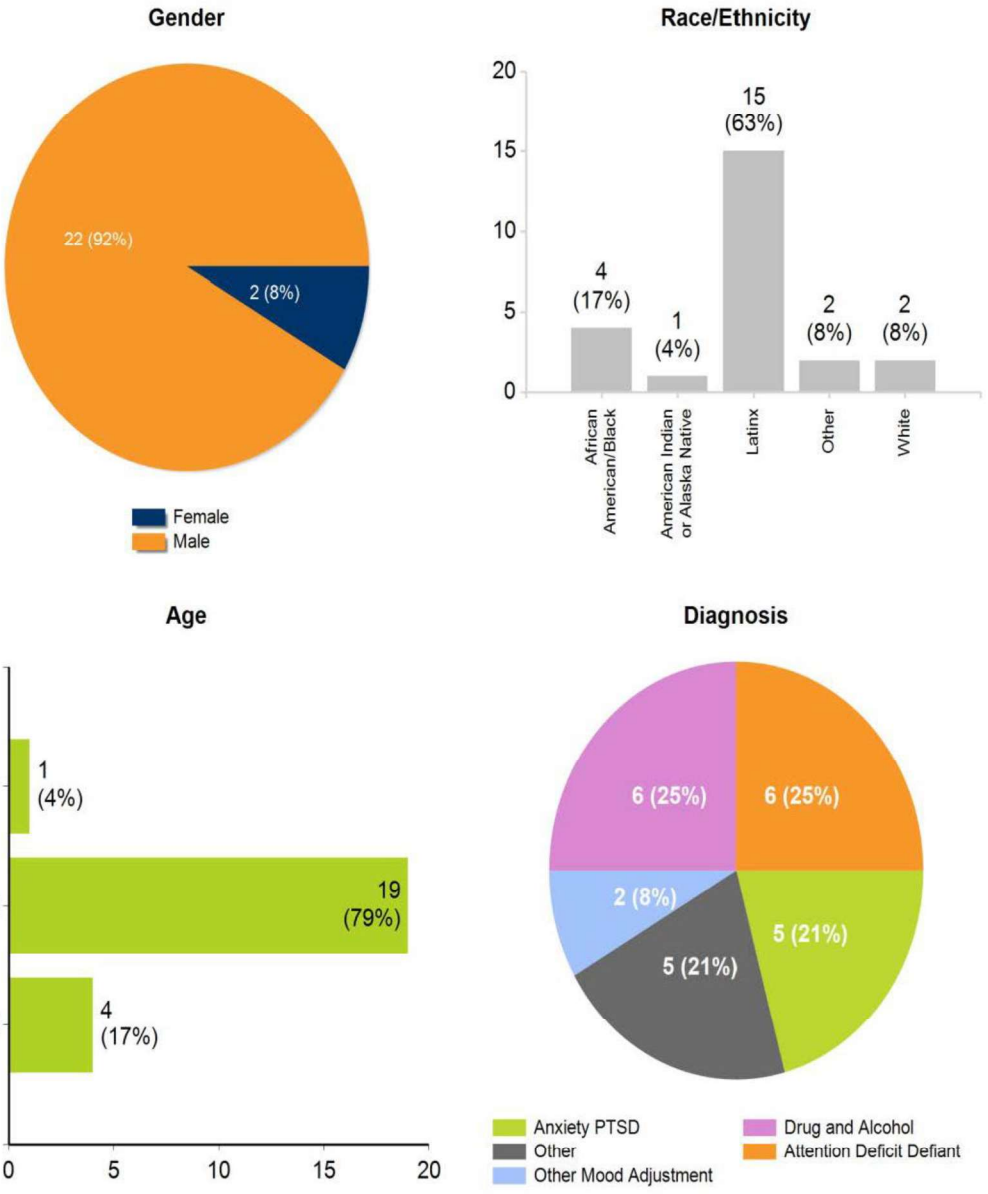
## Children's FSP demographics and Outcomes for: 33OZNCF Served by this reporting unit: 24

### Demographics

92% of consumers were male and 8% were female.

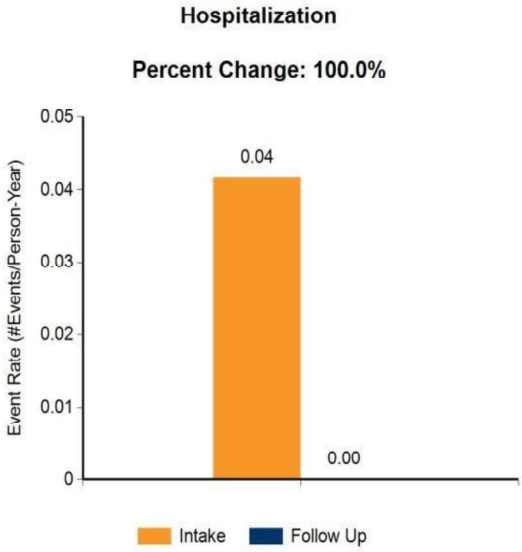
63% of consumers were Latinx, 8% of consumers were White and 17% of consumers were Black/African American.

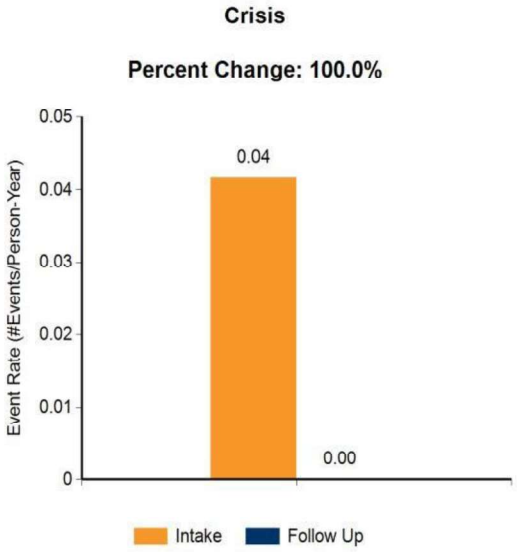
17% of consumers were 15 to 16 years old.

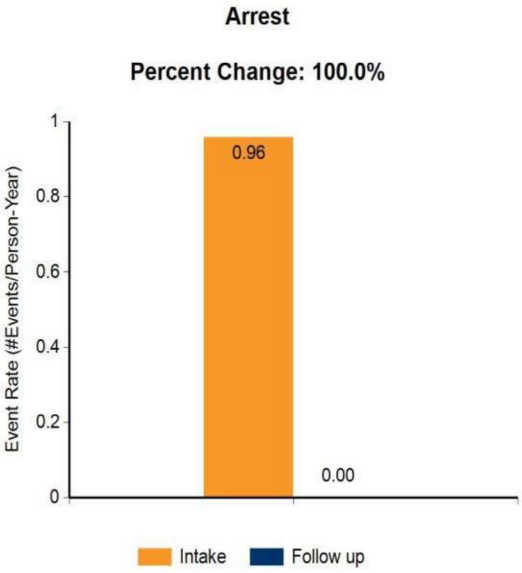


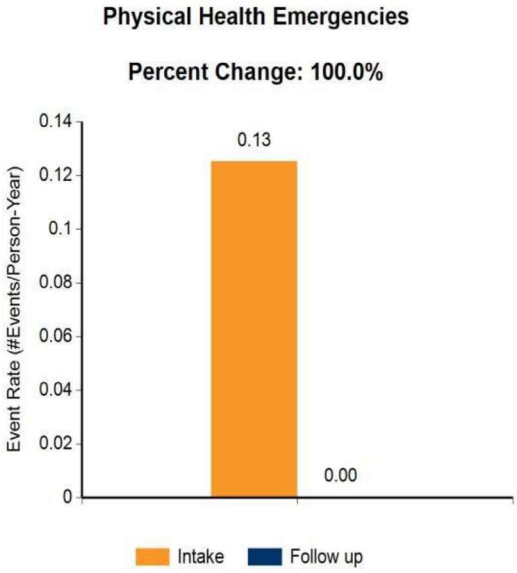
## Outcomes for 33OZNCF

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.



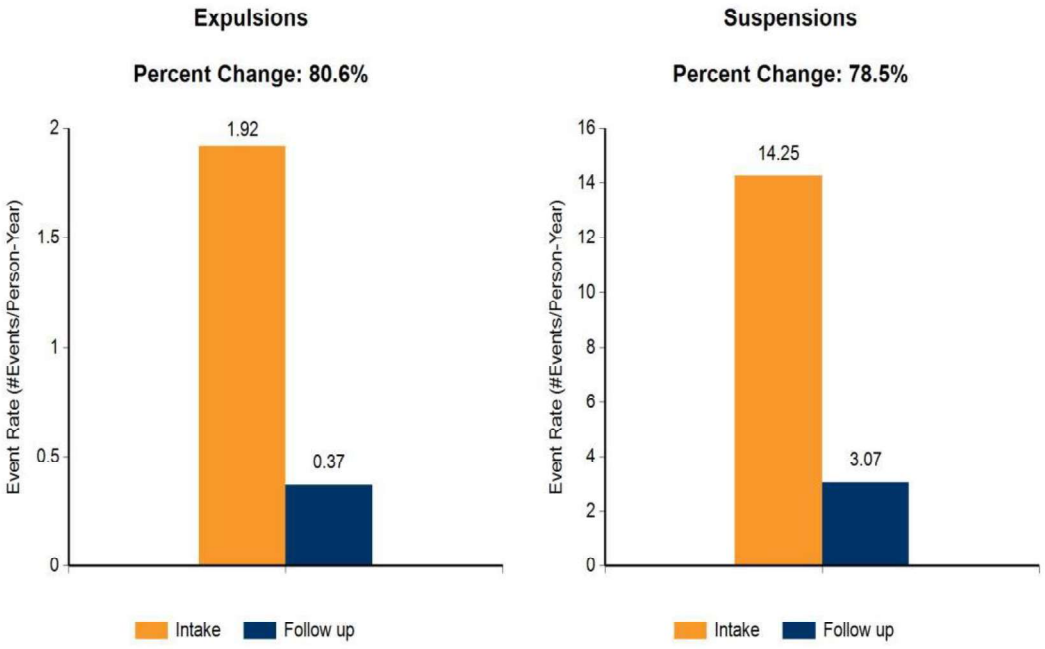




CSS

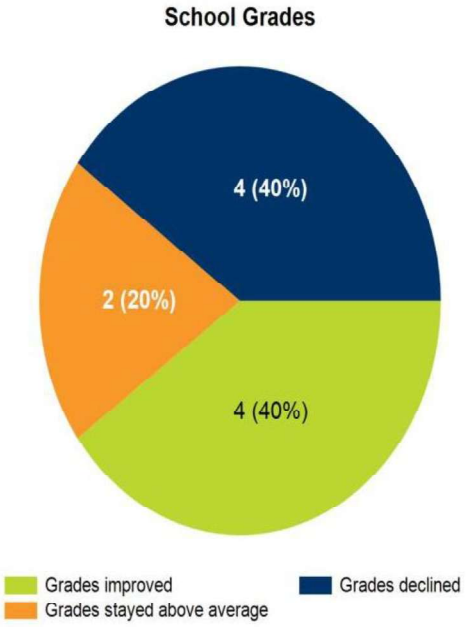
## Outcomes for 33OZNCF (cont.)

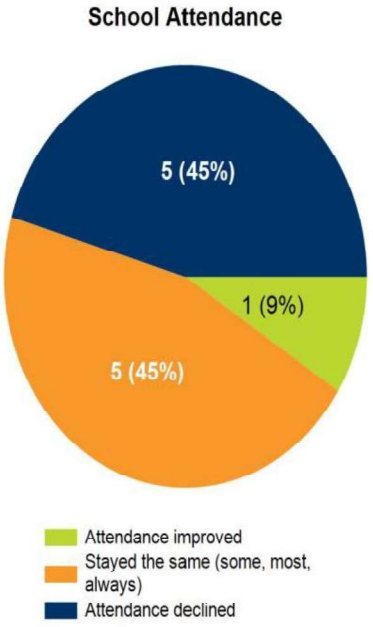
Additional primary outcomes of interest include expulsion and suspension rates, as well as school grades and school attendance.



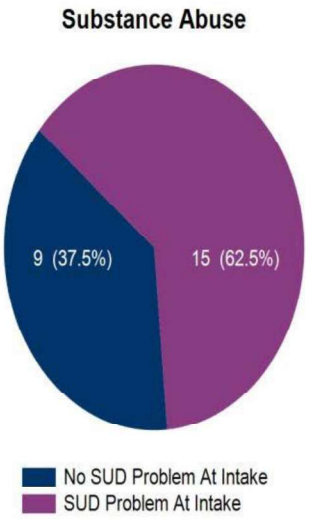


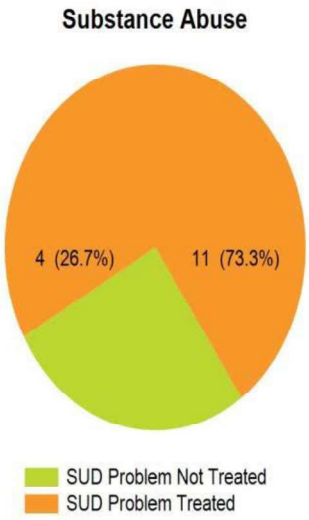




## Outcomes: Substance Use 33OZNCF

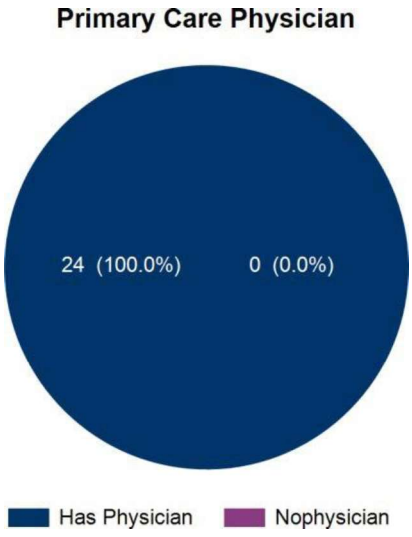



Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (62.5%). The majority of those who had co-occurring MH and SU problems, had been receiving SU treatment services at intake.

An additional 0 consumers not identified at intake were noted to have an SU problem on follow-up and 0.0% of them were reported to be in SU services on follow-up.

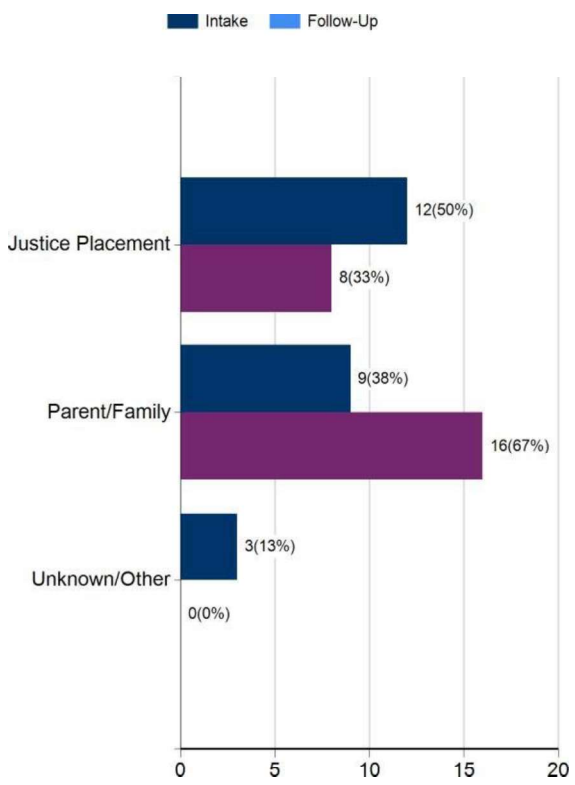
## Outcomes: Primary Care Physician 33OZNCF




Intake: Most consumers (0.0%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 0 consumers that did not have a PCP at intake, 0 (0.0%) obtained a PCP while in the program.

## Outcomes: Residential & Discontinuance (33OZNCF)




| Discontinuation Reason | Count | % |
|---|---|---|
| Justice system | 1 | 10% |
| Met goals | 4 | 40% |
| Moved out of county/area | 2 | 20% |
| Partner cannot be located | 2 | 20% |
| Partner left program | 1 | 10% |
| **Total** | **10** | **100%** |

## Length of FSP Partnership for: 33OZNCF

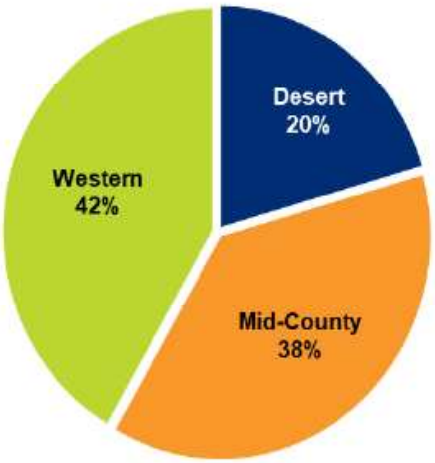
| Youth Time in Partnership | Closed | All Consumers | % of Total |
|---|---|---|---|
| >= 1 Year and < 2 Years | 4 | 4 | 16.67% |
| >= 90 days and < 1 Year | 10 | 10 | 41.67% |
| Under 90 days | 10 | 10 | 41.67% |
| **Total Consumer Enrollments** | **24** | **24** | |

## Service Detail: 33OZNCF

| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr |
|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 1 (17%) | 1 (9%) | 1 (10%) | 6 (40%) | 1 (13%) | 0 (0%) | 1 (50%) | 2 (50%) | 0 (0%) | 0 (0%) |
| 2-3 | 2 (33%) | 5 (45%) | 3 (30%) | 4 (27%) | 4 (50%) | 5 (100%) | 1 (50%) | 2 (50%) | 3 (75%) | 1 (50%) |
| 4-7 | 2 (33%) | 2 (18%) | 3 (30%) | 5 (33%) | 2 (25%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (50%) |
| 8-13 | 1 (17%) | 2 (18%) | 2 (20%) | 0 (0%) | 1 (13%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (25%) | 0 (0%) |
| 14-19 | 0 (0%) | 1 (9%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| 20-25 | 0 (0%) | 0 (0%) | 1 (10%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| Monthly Total | 6 | 11 | 10 | 15 | 8 | 5 | 2 | 4 | 4 | 2 |

| Type of Service | # of Youth | % of Youth | # of Svcs | Avg. # Svcs |
|---|---|---|---|---|
| Case Management | 14 | 26% | 60 | 4.29 |
| Collateral Services | 5 | 9% | 5 | 1.00 |
| Family Therapy | 3 | 6% | 3 | 1.00 |
| IHBS | 1 | 2% | 1 | 1.00 |
| Individual Therapy | 10 | 19% | 37 | 3.70 |
| Intensive Care Coordination Services | 21 | 39% | 158 | 7.52 |

## Children FSP




Children served in FSP program was mostly provided by the Western region with 42% (476) of the clients for the FY 23/24. Followed by Mid-County 38% (432) and Desert with 20% (235). For a total of 1,143 in the FY 23-24.

The table summarizes the number of clients served by RU and region.

| Rus | Desert | Mid-County | Western | Totals |
|---|---|---|---|---|
| 3301FC | 16 | | | 16 |
| 33GYFC | 21 | | | 21 |
| 3385FC | 27 | | | 27 |
| 3357FC | | | 17 | 17 |
| 33A2FC | | | 8 | 8 |
| 33AHFC | | | 84 | 84 |
| 33MOFC | | | 42 | 42 |
| 33MOFEP | | | 17 | 17 |
| 33H8FC | | | 38 | 38 |
| 33AMFC | | 63 | | 63 |
| 33HUFC1 | | 65 | | 65 |
| 33JPFC | | 135 | | 135 |
| 33PCFC | | 142 | | 142 |
| 33GXFC | | 27 | | 27 |
| 33ADFC | | | 246 | 246 |
| 3349FC | 166 | | | 166 |
| 33OPFEP | 5 | | | 5 |
| 33OZNCF | | | 24 | 24 |
| **Grand Total** | **235** | **432** | **476** | **1143** |

# Multidimensional Family Therapy Program

## Western Region: MDFT Expansion

Western Region MDFT Expansion serves the cities of Riverside, Moreno Valley, Corona, Norco, Eastvale, and the unincorporated areas of Jurupa Valley, Lake Matthews, Home Gardens, and parts of Mead Valley. MDFT Western Region Expansion team currently consists of three Clinical Therapists, one Supervisor, and one Office Assistant II. The Behavioral Health Specialist II position is presently vacant. The Behavioral Health Services Supervisor (BHSS) for MDFT Western Expansion is also the Supervisor of Mid the county MDFT program.

Noted trends in the Western Region service area include the continued use of sprayed Marijuana by youths in the program. This form of consumption leads to higher intoxication, reduced appetite, increased anxiety and depression, and lack of ability to regulate emotions, leading to more volatile behaviors that include physical aggression and destruction of property. In addition, there was a decrease in fentanyl use by youths but an increase in nicotine vaping and consumption of eatable substances. The program continues to have difficulty accessing members when they're in school. The program also consistently saw youth with a trauma history (sexual abuse, immigration-related trauma, and other cultural issues).

**Goals for the next three years include the following:**

1) Cross-train staff to use other intervention models to address trauma issues. Have staff be trained in the Dialectical Behavioral Therapy model to address emotional dysregulation.

2) Continue doing live supervisor or DVD reviews every month.

3) Create an MDFT leadership committee responsible for planning and implementing a yearly booster that brings together MDFT teams in the county for training and support purposes.

4) Collaborate with school officials to get access to members at school during school hours to provide services.

Notable Data Points:

- 38 consumers were served for FY23/24
- 54% of consumers were male and 46% were female
- 51% of consumers were 15 and 16 years old
- Increase in hospitalization (157% change)
- Decrease in arrest (100% change)
- Decrease in school expulsions (76% change) and suspensions (73% change)

## *Mid-County MDFT*

Mid-County MDFT currently has four Clinical Therapists (1 Clinical Therapist II, 2 Clinical Therapist I, and 1 Clinical Therapist III). The Clinical Therapist III recently completed the MDFT International Trainer Course and is now a certified MDFT trainer. The program also has two Behavioral Health Specialists. One of the BHSII recently completed the 20/20 program that allowed her to pursue a master's program in Social Work and is expected to move on from this position. There is a Certified Nurse's Assistant performing the role of a Community Services Assistant, and the vacant Office Assistant Position II was recently filled. The program is supervised by one Supervisor who also oversees the Western Expansion MDFT program. The mid-county MDFT team serves the cities of Perris, Murrieta, Temecula, Wildomar, Lake Elsinore, Hemet, San Jacinto, and the unincorporated area of Anza.

A noted trend in Mid-County is there are more adolescents using fentanyl. In addition, more adolescents are using sprayed Marijuana, which results in being overwhelmed with toxicity that leads to no appetite, anxiety, depression, and lack of ability to regulate emotions. All of the above resulted in adolescents being opened to programs with more severe emotional and behavioral disturbances. Another challenge is adolescents being raised by non-biological parents (aunts/uncles, other relatives); Parent has their own mental illnesses and substance use; adult caretakers working longer hours and are unavailable for family or parent sessions; staff is not able to see consumer at school due to school district prioritizing school instructions over counseling; difficulty getting adolescent to stop marijuana use given change in drug enforcement priority by probation partner.

**Goals for the next three years include the following:**

1) Maintain fidelity to the model by filling out vacant positions quickly and training them accordingly so the team can have a sense of cohesiveness.

2) Continue having clinical therapists do live supervision and taping of sessions for review on a regular basis.

3) Increase staff exposure to models that address what's new in terms of street drugs, toxicity, anxiety, and depression. Newer staff that were hired are less experienced in treating co-occurring diagnoses such as depression and anxiety.

4) Plan and develop an MDFT semi-annual summit to bring together the three different MDFT teams for training and support purposes. This was a previous goal, but it was postponed when the Department MDFT trainer retired.

Notable Data Point: Research needs to fill in this section

## *Desert Region MDFT Program*

MDFT Desert Region is now fully staffed with three Clinical Therapists, one Behavioral Health Specialist II, one Community Service Assistant, one half-time Office Assistant III, and one Supervisor. The MDFT Supervisor also supervises the TAY Desert Flow Drop-In Center. MDFT Desert Region serves the Coachella Valley areas, including Indio, Desert Hot Springs, Palm Springs, La Quinta, Palm Desert, and the Salton Sea community.

Noted trends for Desert Region MDFT saw consistent referrals from the probation department and county clinics and increased referrals of youth with aggression whose parents work long hours or who are being cared for by other family members. The Desert MDFT team also had an increase in youth with depression and suicidal ideations, along with youth with increased ADHD diagnoses and those dealing with cultural stress and trauma. The desert MDFT program also had a reduction in gang-involved youth.

**Goals for the next three years include the following**:

1) Increase LIVE and DVD supervision.

2) Cross-train staff to other models of intervention to address trauma issues. Have staff be trained in the Dialectical Behavioral Therapy model to address emotional dysregulation.

3) Create an MDFT leadership committee responsible for planning and implementing a yearly booster that brings together MDFT teams in the county for training and support purposes.

4) Increase staff knowledge on navigating the school system for resources such as testing for learning disability.

Notable Data Points:

- 21 consumers served during FY23/24
- 73% of consumers were male and 27% were female
- 50% of consumers were 15 and 16 years of age
- Significant decrease in hospitalization and arrest (100% change)
- Significant reduction in expulsion (80.6% change) and suspension (78.5% change).

## *Wraparound Program*

Wraparound provides eligible youth and their families an alternative to congregate or higher levels of care (such as STRPs and out-of-state placement). Wraparound intends for children and adolescents to remain/return to a lover level of care in a family setting. In Riverside County, Wraparound began in 2003 with the Riverside University Health System- Behavioral Health (RUHS-BH) serving children at risk for high-level placement. Wraparound was provided to youth on probation, who voluntarily participated, and were diagnosed with a Severe Emotional Disturbance (SED).

The foundation of Wraparound is based on partnering with families to provide individualized support based on their unique strengths. It is needed in order to promote success, safety, and permanence within the home, school, and community. Program staff work with the family to develop a Wraparound team, which is comprised of a Facilitator, Behavioral Health Specialist, Parent Partner, and in some cases, a TAY Peer and a Therapist from RUHS-BH, a Public Health Nurse, and a Probation Officer. The team also includes anyone the family sees as essential in their lives, such as extended family members, friends, or other community members. As part of the Wraparound process, the team develops a family plan based upon "family voice and choice", to guide the process focusing on ten life domains:

| | |
|---|---|
| 1. Family | 6. Financial |
| 2. Housing | 7. Spiritual |
| 3. Safety | 8. Legal |
| 4. Social Recreational | 9. Emotional/Psychological |
| 5. Medical/Health | 10. School/Work |

Wraparound has operated as an FSP Since October 2018 and provides a majority of services to the families and youth in the community (schools, home, other locations) with 3-5 services a week. In the past year, Wraparound programs have expanded to increase SED service to Medi-CAL recipients, clinical Therapists received training in Trauma-Focused Cognitive Behavioral Therapy and added Substance Abuse intervention support with BHS III positions. Also, the team is preparing for upcoming training in High-fidelity Wraparound from the Heroes Initiative with a three day "Wrap Camp" to meet regulatory expectations and enhance fidelity across regions.

Overall/ County wide accomplishments for 2023/2024, please see individual program reports below.

## *Western Region Interagency Services for Families (ISF) Wraparound:*

Progress from 3-year plan.

- Expand services to non-minor dependents returning from probation placement.
    - Wraparound services have been offered to non-minor dependents, and the supervisor has reached out to various probation offices, but ISF has not received many referrals for non-minor dependents.

- Expand services to Medi-Cal recipients who are on informal probation
    - The Probation Department has been made aware that we can provide Wraparound services to youth on information probation, but the Probation Department has not started sending referrals over yet for kids on informal probation.

- Filling staff vacancies to support three complete teams in fidelity with the model and support increased service provision.

- The ISF Wraparound Program is fully staffed currently

- Continued participation in the Wraparound Training Collaborative to expand regularly scheduled Wraparound basic and advanced training and ensure the provision of high-fidelity Wraparound services.
    - The ISF Wraparound staff continuously receive training from the UC Davis training site on Wraparound topics.

- Cross-train staff in all roles to ensure flexibility and continuity of service.
    - All ISF Wraparound staff have been cross-trained and can facilitate cases.

- Collaborate with probation to ensure the second probation officer position is filled to expand the capacity to serve probation youth.
    - The number of probation referrals has been low in the past year, so we have not been able fully utilize the capacity of our one probation officer.

- Reorganize ISF Wraparound team assignment structure to increase capacity for service delivery.
    - ISF Wraparound team structure has been adjusted so that Clinicians are devoting more of their time to provide individual, group, and family therapy for our Wraparound members, and the Wraparound facilitation role has been covered by other positions.

- Fill position of TAY Peer to provide peer support services for youth.
    - The TAY peer position was filled, but ISF still has a need for additional TAY peer positions, especially to work with gang-involved youth.

- Resume regular youth outings for social skill building and resume Wraparound events such as Honor Night and Unity Day to acknowledge family's successes.
    - The ISF Wraparound Program has hosted several youth activities over the last year and plans to host an Honor Night and Unity Day in the next few months.

- Participate in "Riverside Partnership" meetings with other Wraparound programs for mutual support and sharing of learning regarding best practices.
    - The ISF Supervisor participated in several Riverside Partnership meetings in the past year to get additional ideas on innovation from other Wraparound Programs.

### *Mid-County Region Interagency Services for Families (ISF)*

The Mid-County Wraparound Team has continued to expand services, including outpatient clinic, IEHP, and non-ward Probation referrals. The Mid-County team is comprised of one Behavioral Services Supervisor, 1 Office Assistants, 3 Clinical Therapists, 1 Behavioral Health Specialist III, 5 Behavioral Health Specialist II, 6 Peer Support Specialists (Parent Partners), 2 Peer Support Specialist (TAY), 1 Community Services Assistant (position currently vacant), 1 Public Health Nurse

and 2 Probation Officers. The Mid-County team provides 90% of their services in community settings such as the family home, schools and other community options (local clinics, libraries, etc.).

Notable trends in Mid-County services include a continued increase in utilization of our safety line, primarily from non-SB families. Services continued to increase to non-SB children, providing early intervention to these families. Referrals for non-SB children continue to surpass referrals for SB children. Non-SB referrals have been expanded to include referrals from IEHP and non-ward probation youth who have Medi-Cal. In particular, referrals from System of Care clinics have increased drastically this year. Since beginning to receive non-ward referrals last year, we have provided a presentation for the SPARK program which partners with probation and have seen a drastic increase in referrals from this source, some of whom were found to be wards and were able to be transferred to the SB caseload. Requests for therapeutic services through Wraparound have continued for both identified client and family members.

**Progress on 3-Year Plan Goals:**

- Improve collaboration with local clinics and providers for Non-SB referrals and services.
  The previous year's referral level has increased for this group of youth. CalAim has allowed for better collaboration and streamlining of services for these referrals. Relationships with IEHP case managers and supervisors at System of Care Clinics have improved, and referrals have increased from these sources.

- All staff attain proficiency in high-fidelity Wraparound.
  Wraparound topics continue to be discussed weekly in staff meetings and case reviews. We utilize a wraparound-specific case review sheet to ensure principals are addressed when consulting. We are taking the whole program through the Wraparound process and have developed a mission statement and goals. Facilitators have regularly met with Jennifer Hunter for coaching, which appears beneficial. Many staff have also attended online trainings sponsored by UC Davis throughout the year.

- Increase direct contact with local Probation offices to improve collaboration and services.
  Continued staff turnover at Probation has made ensuring they are well-informed about Wraparound challenging. Still, we are working with the local supervisors to help identify appropriate youth earlier. Probation has shifted from a regional Wraparound Probation Officer to having a designated Wraparound Probation Officer at each location. There has been an adjustment period in creating clear lines of communication and maintaining probation attendance in consults and staff meetings. A team of Wraparound staff completed a presentation at one probation site that was well received and is coordinating a presentation at the other site. They plan to continue these presentations regularly.

- Build community partnerships via contact with Churches and community centers.
  Currently on hold due to vacancy in Community Services Assistance position

## *Desert Region Interagency Services for Families (ISF)*

**2023/24 Accomplishments**

- Seven successful Wraparound graduations and many other cases progressed while with us.
- Increase in more field-based services as a result of reduced Covid fears – this resulted in an increase in IHBS billed services
- Increase focus, teaching, and implementation of the Wraparound Principles with families.
- Improved working relationships with the Probation Department. The newly assigned probation supervisor and our assigned probation officers attend most Wraparound staff meetings. She is included in case consultations as needed. Probation has been very open to learning more about the Wraparound Program, its principles, and the overall Recovery Model. It's been wonderful!

There has been an increase in community engagement, leading to youth and families being exposed to new experiences, healthier activities, services, and local resources. Here are a few highlights:

1) The team established a relationship with the manager at the Indio Municipal Golf Course, which resulted in a complimentary golf driving range for our kids. Three youths discovered golf for the first time and love it!

2) Following our meeting with the manager, Living Desert Zoo and Botanical Gardens now provides us with a free "chaperone" ticket, maintaining a 1:1 youth-staff ratio! Peers and BHSs took four youths there for their first visit, and they all enjoyed it immensely.

3) We met with Birth Choice of the Desert staff and learned about their services. They have strongly supported our expecting teen, both before and after the birth and long after her successful WA graduation.

Jennifer Hunter started providing regular individual coaching sessions with our facilitators this past year. This has resulted in the facilitators feeling well supported, increasing their self-confidence, learning, and adherence to the high-fidelity Wraparound model.

The TAY Peer Support Specialist was hired this past year, marking the first time we had one in many years. He was heavily involved in gangs and drugs during his youth and into adulthood. Our kids involved in gangs' bond and connect with him exceptionally well. He has truly helped them realize that a new life path is possible. He bridged a significant gap that we had experienced for a long time. Our youth show great trust and respect for him.

## 2025 Goals

- Continue to strive towards establishing new local vendors
- Increase number of referrals by educating both POs and other BH programs about our services
- Continue to strive towards decreasing financial stress on staff in terms of accessing our funding and being able to deliver those services to families. Hoping for availability of Gift Cards to reduce staff needing to put consumer goods on their own credit cards.
- First time - TAY PSS position now open to Blythe. Will be interviewing soon!!!

- Increase Senior Peer involvement in Wraparound, including 1:1 and group coaching with PPs and TAY PSSs. Senior Peers will be presenting Recovery Language presentation at the March All-Staff meeting, which will include POs and PHN.
- At the monthly all-staff meeting, each of the four clinics will rotate presenting activities/icebreakers to everyone that they can take back to their Wraparound families to make sessions more fun, interesting, and engaging. More sharing of ideas with each other will increase team bonding.
- Increase community engagement by attending more community events and collaboratives.
- Acquire more county cars to be able to deliver needed IHBS service
- Strive towards getting staff approved for the Wraparound conference, June 12-14 in Garden Grove.
- Continue with Wraparound facilitator coaching by Jennifer Hunter
- Improve coworker relationships through team-building activities once per quarter.

## *Youth Hospital Intervention Program (YHIP)*

### *Western Region YHIP*

Western YHIP team works collaboratively to provide intensive full-service partnership (FSP) outpatient mental health services for youth at risk for psychiatric hospitalization and/or post-discharge for suicide attempts and self-injurious behaviors. YHIP's primary goal is to decrease inpatient admission and crisis psychiatric emergency department recidivism by increasing stabilization and enhancing safety. Areas of catchment for Western YHIP are Moreno Valley, Riverside, Corona, Jurupa Valley, Eastvale, and Norco.

Western YHIP collaborates with the consumer to develop treatment plans and goals. The program encourages the participation of support persons (family or others) to increase support systems and to help members achieve and maintain their mental and behavioral goals. Western YHIP offers a variety of options for treatment, including individual psychotherapy and family therapy, parent support and psychoeducation, transportation, linkage to medication management, case management, and crisis support after office hours.

Western YHIP proudly reports that we are fully staffed with one Behavioral Health Service Supervisor, four Clinical Therapists, two Parent Partners, one TAY Peer, one BHS II, and one Office Assistant. All clinicians are trained to use the Child Adolescents Needs and Strengths Tool (CANS), and all staff members are trained in cultural competency.

Since September 2024, Behavior Health Specialist II and Certified Medi-Cal Peer Support Specialist have provided a weekly support group for teenagers. The goal is to provide a safe place where youth can feel heard and validated while acquiring life skills. Youth sharing everyday experiences helps them to feel less isolated and lonely and increases trust in forming healthy connections. The team empowers members to increase their independence by assisting them to develop effective coping strategies for their symptoms and gain valuable skills to reinforce healthy mental gains.

Western YHIP currently has two clinicians enrolled in TFCBT training. Three clinicians are 5150 certified to help clients who are dangerous to themselves or others. The Certified Medi-Cal Peer Support Specialists continue to use their story to offer support, information, and guidance based on their lived experience to help families make positive transformations for themselves and their children.

**Goals for the next three years include the following:**

1. Strengthen community connections by inviting representatives of community organizations to give presentations to promote learning and increase resources.
2. Increased in-home and community-based services.
3. Increase collaboration between school districts and YHIP to reinforce support for youth encountering academic difficulties and social struggles and address barriers to school attendance due to mental health challenges.
4. Continue to increase collaborative work and care coordination with contract providers to ensure timely linkage and support of mental health services.

## *Mid- County Region YHIP*

Mid-County YHIP services children and youth hospitalized or at high risk for hospitalization. We also support children and youth who are stepping down from residential placement and need a full-service partnership (FSP) level of support as they transition. Riverside University Health System—Behavioral Health provides this service.

Mid-County YHIP is one of three YHIP programs throughout the County that provides crisis stabilization for children and youth. YHIP's primary purpose and goal is to decrease children's return to or cycling in and out of hospitalization. YHIP seeks to support the child or youth until they can enter an appropriate lower level of support (e.g., a County clinic, SAPT services, other specialty services, or a community provider).

The program faced challenges in staff retention and referrals in the 2023/2024 reporting period. With the loss of staff and the program supervisor, the program was "paused" in February 2024, and the remaining staff dispersed into other programs while restructuring and hiring could occur. With that, progress to goals was minimal for the reporting period.

**The following are the goals for Mid-County YHIP and the updates associated with those goals:**

1. More training and collaboration from other agencies such as DPSS, Probation, other County & contract providers,

Mid-County YHIP made marginal progress on this goal for 2023/2024. The dominant collaboration was internally with Youth Connect and externally with IEHP-Inland Empire Health Plan. The increase in this area with the program "restart" will expand referral sources and collaboration.

2. Increase collaboration with SAPT

No notable gains in this area.

3. Improve outcome data through training
Ongoing training for improved completion of the collection of FSP data proceeded throughout the time the program was operating.

4. Increase collateral support for all partners
Staffing shortages and a lack of referrals created barriers to growth in this area.

5. Increase linkage to primary care physicians
With increased regular contact with Case Managers at IEHP, this goal showed improvement in linkage and follow-through for "Well Child" visits and other physical health services.

**Current staffing:**
0.5-Behavioral Health Service Supervisor
0.5-Senior Clinical Therapist
1- Office Assistant III
1-Office Assistant II
4- Clinical Therapists
2- Behavioral Health Specialists
2- Parent Partners
1- Transitional Age Youth Peer

### *Desert Region YHIP*

Desert YHIP (fully staffed) comprises four Clinical Therapists, two Parent Partners, two TAY Peer Specialists, one Behavioral Health Specialist III, and one Office Assistant III. Desert YHIP currently serves the following areas: Banning, Palm Springs, Desert Hot Springs, Palm Desert, La Quinta, Indio, Coachella, Thermal, and other surrounding Desert Cities. Services are offered in person, field-based, clinic settings, and/or through telehealth for individual, family, collateral, and/or group services. Parent Partners provide individual services for parents in both English and Spanish as supportive services and an introduction to the program. Our TAY Peers facilitate individual skill-building sessions using the WRAP Model (Wellness Recovery Action Plan). Services are delivered weekly with 2-3 contact sessions per week by one of the staff members utilizing evidence-based models such as Cognitive Behavioral Therapy, Trauma-Focused Cognitive Behavioral Therapy, and Dialectical Behavioral Therapy. The program continues to assist individuals and their families in reducing hospitalizations by equipping them with the knowledge and skills to lower at-risk behaviors and understand mental health challenges. One challenge during this update is that the only clinician assigned to the program transferred, which caused new referrals to be paused while we worked to backfill clinical positions.

**The goals will be as follows:**
1. Adding groups such as a SAFE/Urgent Care group, LGBTQI+ group, Anger Management group, DBT group, and parenting groups, both in English and Spanish, to decrease symptoms and

provide psychoeducation on symptomology when the program is staffed. Update: The goal was not met due to low staff, but the goal will continue to be a focus.

2. Increased utilization of the CANS (Child Adolescent Needs & Strengths) tool in Child and Family Team Meetings, as well as using the CANS to help navigate the course of treatment. Update: The team continues to ensure that CANS can be implemented and reviewed during CFTMs. The treatment team has been working on completing CFTMs at the beginning of treatment to assist with meeting the requirements of the FSP program. Challenges continue to be CFTMs being done promptly and challenges with parent/guardian availability and participation.

3. More integration of substance abuse services and groups for youth who struggle with co-occurring disorders. Update: The program has a BHS III that has been working on getting consumers linked to services and provides support and psychoeducational treatment to youth and parents/guardians but has struggled due to low census.

4. Reduce the no-show rate by offering home, community, and/or school services. Update: The goal has been met; the team has done a good job of providing services where the consumer is to avoid any barriers to treatment.

5. Link youth and families to appropriate community resources, identifying any cultural and linguistic special needs the family may have to assist with treatment success and forming more community relationships. Update: The goal continues to be ongoing, but there has been success in ensuring linkage between the program and community resources to ensure support and success for the youth served.

6. Provide TF-CBT, EMDR, and/or DBT training for all staff. Update: This goal continues to be a priority. A previous clinician was trained in TF-CBT, but the program is currently without a clinician. All staff is currently trained in DBT.

## Outpatient System of Care Children's FSP Tracks

### Western Region Children's Clinics FSP Tracks

The Western Region Children's Clinic FSP tracks are located at Moreno Valley Children's Interagency Program (MVCHIP), Children's Treatment Services (CTS), and Riverside Family Wellness Center. These tracks are designed for youth that need intensive, specialty mental health services including but not limited to Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), Therapeutic Behavioral Services (TBS), individualized treatment planning, care coordination with outside agencies (e.g., DPSS, School Districts, Probation, IRC), psychiatric, therapeutic, and group services. The youth identified for FSP services are our most vulnerable youth with complex conditions such as trauma and suicidal ideation, or youth who are in foster care, justice-involved, or homeless, or at risk of homelessness.

**Annual Update:**

98 youth enrolled in the Western Region Children's FSP tracks for FY23/24. Children's Treatment Services (CTS) Clinic FSP track enrolled and served 17 children. Most children served were between 15 to 16 years old (47%). CTS had an 18% reduction in Hospitalizations and a 33% reduction in Crisis emergency room visits. Arrests were down 100%. Both expulsions and suspensions were down 90% and 89%, respectively. The Moreno Valley Children's Interagency Program (MVCHIP) FSP track enrolled and served 42 children. 29% of members were aged 15 and 16 years of age. Hospitalizations and crisis emergency room use decreased by 68%. MVCHIP members had a 90% reduction in school expulsions and a 89% reduction in suspensions. Riverside Family Wellness FSP track enrolled and served 39 children. 54% of the children served were male, and 51% were between the ages of 15 and 16. There was a decrease in hospitalization and crisis emergency room visits (68%). Suspensions and expulsions decreased, and school grades and attendance improved.

FSP consumers in the Western Region needing after-hours support are connected to the Mobile Crisis Unit or CARES line for additional support. For the extremely high-need and high-risk FSP consumers, the Western Region children's program continues to utilize internal resources. CTS, MVCHIP, and Family Wellness have access to MDFT, YHIP, and ISF Wraparound's after-hours support line. The close collaboration between the outpatient and field-based programs allowed for better coordination and awareness of the specific needs of the FSP consumers.

FSP level of care requires much time outside the traditional outpatient clinic, serving consumers in more natural supportive environments (e.g., home, school). The Western Region Children's goal for the year is to continue increasing Intensive Case Management (ICC) services and Intensive Home Base Services (IHBS). The region has hired additional support staff to address the need for more ICC and IHBS services.

Progress Data for FY23/24 (Countywide): The Children's FSP served 1099 youth in the Children's FSP tracks. Overall, 42% of the Children's FSP consumers received 8 or more monthly services. Combined outcome data for all children's FSP programs showed a decrease in arrests (92.52 %), physical health emergency department visits (86.97%), and hospital admissions (15.70%).

## *Mid-County Region Children's Clinics FSP*

### Mid-County: Victor Community Support Services Children's FSP

Victor Community Support Services (VCSS) Children's Full-Service Partnership (FSP), contracted with Riverside University Health System-Behavioral Health, serves youth ages 0-21 in the mid-county region of Riverside County from offices in Perris and Hemet. Our primarily community- and home-based services address high-risk needs, including psychiatric hospitalization, housing/school instability, removal/risk of removal from home, substance use, juvenile justice involvement, suicidality/violence risk, eating disorders, and the need for Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), or Therapeutic Behavioral Services (TBS). Using a strength-based approach and evidence-based practices like TF-CBT, our multi-disciplinary teams provide comprehensive mental health services, including individual, family, and group therapy; medication support; rehabilitation/behavioral support; skill building; case management; parenting support; and substance abuse/TBS referral and linkage.

**Program Goals:**

**1) Reduce Referral Wait Times**

- Target: Meet access to care timelines.
- Current Performance (January- December 2024):
    - Hemet: 33.2 days
    - Perris: 27.5 days

**2) Maintain Treatment Goal Achievement**

- Target: 75% or higher.
- Current Performance (January - December 2024):
    - Hemet: 82%
    - Perris: 86%

**3) Increase Utilization of ICC, IHBS, and CFTMs**

- Target:
    - Hemet: 70%
    - Perris: 50%
- Current Performance (January - December 2024):
    - **ICC Services:**
        - Hemet: 94%
        - Perris: 39%
    - **IHBS Services:**
        - Hemet: 53%
        - Perris: 16%
    - **CFTMs:**
        - Hemet: 39%
        - Perris: 9%

**4) Other Notable Data**

(January - December 2024):

**Clients Served:**

- Hemet: 222 clients
- Perris: 178 clients

**DEMOGRAPHICS**

- VCSS Hemet
    - 46% Male
    - 54% Female
    - 15% African American/Black
    - 26% Caucasian

- 48% Hispanic/Latinx
- VCSS Perris
  - 35% Male
  - 64% Female
  - 10% African American/Black
  - 10% Caucasian
  - 52% Hispanic/Latinx

**AVERAGE LENGTH OF STAY**

- VCSS Hemet: 7.2 months
- VCSS Perris: 11.7 months

**3- Year Plan Goals:**

**1) Models of Care Implementation:**

Implement a robust Model of Care framework to improve service delivery, ensure consistency, utilize best practices, and ultimately enhance consumer outcomes. Our framework provides a roadmap for effective and efficient service delivery, prioritizing service excellence by addressing the specific needs of the populations we serve. A key component is the use of standardized assessment tools to track client progress and identify areas requiring additional support.
We leverage the following assessments:

- Child and Adolescent Needs and Strengths (CANS): Assesses the mental health needs of children and adolescents.
- Client Assessment of Reintegration Scales (CAIR): Assesses the functional abilities of consumers with mental illness.

CAIR scores play a critical role in our Models of Care, enabling us to:

- Stratify consumers: Match consumers to the most appropriate model of care/program.
- Determine service frequency: Tailor service intensity to individual needs.
- Monitor treatment progress and length of service (LOS): Track client progress over time.
- Evaluate client outcomes: Measure the effectiveness of interventions.

**2) Improving Outcome Data through Training:**

We are committed to improving outcome data through ongoing staff training in evidence-based practices (EBPs). Over the past year, we have made significant progress in this area, providing training in:

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Dialectical Behavior Therapy (DBT)
- Family-Based Therapy (FBT)
- Incredible Years
- Family Seeing (Family Finding Model)

This investment in staff training ensures the delivery of high-quality, evidence-based care and contributes to improved client outcome

MENTAL HEALTH SERVICES ACT (MHSA)

FULL SERVICE PARTNERSHIP PROGRAM

*FULL-SERVICE Partnership TAY Outcomes Report*

# FY 2023-2024

## Background

The following report summarizes outcome data for the TAY Full-Service Partnership (FSP) programs. FSP program outcomes are focused on evaluating changes in a consumer's status relative to several quality-of-life domains. Baseline histories are obtained from consumers at enrollment into the FSP program. Follow-up data is collected continuously for key life events (e.g., hospitalizations) and is assessed periodically for other select life domains.

Outcome reporting is based on comparisons between baseline and post-enrollment status and provides a measure of program effectiveness.

The following report is based on FSP data collected from consumers enrolled in and served by the TAY FSP programs, starting July 1, 2023, and ending June 30, 2024. The baseline data for this report relies on responses from each consumer's Partnership Assessment Form, alongside the history of events from the 12 months prior to a consumer beginning the FSP program. Follow-up data utilized in this report comes from two sources. Psychiatric Hospital and crisis emergency room data have been drawn from actual hospital or crisis emergency room admissions. All other follow-up data included in this report is derived from Key Event Tracking (KET) and Three Month Quarterly (3M) assessment forms completed on ImagineNet during these consumers' enrollment in the TAY FSP program.

## FSP Program

Overall, the FSP programs provide an intensive level of service with regionally placed Integrated Service Recovery Centers (ISRC) for Adult and TAY consumers and Specialty Multidisciplinary Aggressive Response Treatment (SMART) for older adults. However, the following report only presents statistics and figures from the TAY FSP programs.

Three TAY ISRCs provide intensive case management services with support and crisis response services available 24/7. ISRCs include our three programs, which are located regionally and serve consumers who are unengaged and homeless or at risk of homelessness. The program also targets consumers with a history of cycling through acute or long-term institutional treatment settings. These centers collaborate with community resources and agencies to meet consumers' vocational, educational, social, and housing needs. Services are provided by a multidisciplinary team that embraces the principles of recovery and resilience. The services and support staff available within the ISRC include psychiatric services, vocational specialists, housing specialists, substance abuse counselors, peer support/mentorship, family education, family advocacy, educational support, and benefits specialists.

## Executive Summary

***TAY Enrollment and Demographics —***During the 2023/2024 fiscal year, from July 1, 2023, to June 30, 2024, a total of 689 youth were served through 705 enrollments, which include re-enrollments and transfers to one or more of the TAY FSP programs. The race and ethnicity of enrollees for this fiscal year were 319 (45.2%) Latinx, 87 (12.3%) White, and 63 (8.9%) African American/Black. Countywide, the most common diagnosis among TAY FSP consumers was Major Depression, with 193 (29.2%) cases. Additionally, the most significant proportion of consumers was between the ages of 18 and 21 (53%), and the majority of those enrolled were male (57%).

***TAY Discontinuances*** —Across all of the TAY programs, the most frequently reported discontinuance was that the partner could not be located (36%). Partner left program accounted for (23%) of discontinuance reasons.

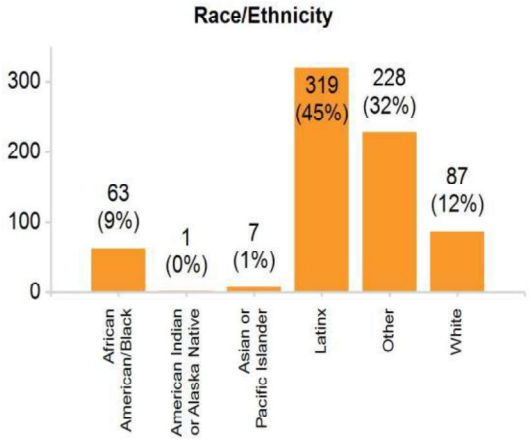
***FSP Services*** —In the 2023/2024 fiscal year, more than half of the FSP consumers received 2-3 or 4-7 services a month. The highest average hours of services during the 2023/2024 fiscal year were for individual mental health services (8.32 hours), in-home behavioral services (6.23 hours), and individual therapy (10.47 hours).

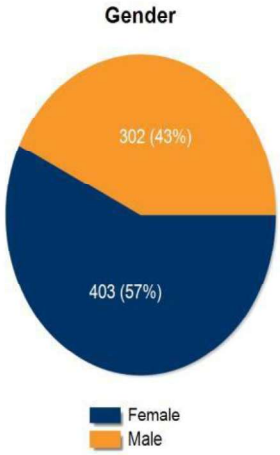
***TAY Outcomes*** —Follow-up data for all TAY programs combined showed a decrease in hospitalizations (31.4%), arrests (79.8%) , physical health emergency (82.2%), and mental health emergency department visits (30.1%). A small percentage of consumers did not have a primary care physician at the beginning of the program (21.21%). However, more than half of those (53.7%) obtained one while in the FSP program. Although the majority of those with a co-occurring substance use problem were not receiving treatment at intake, many (25.0%) participated in substance use services while in partnership. Of the 50 additional consumers who were identified as having an active substance abuse problem during their participation in the TAY programs,4(8.0%) was reported to be participating in substance use treatment services while in the FSP program.

***Residential Status—***Comparisons of intake status and most recent residential status showed that while the majority of consumers continued living with their parent/family, the percentage of consumers reported as living on their own, in supervised placement***,*** or in a residential treatment facility increased.

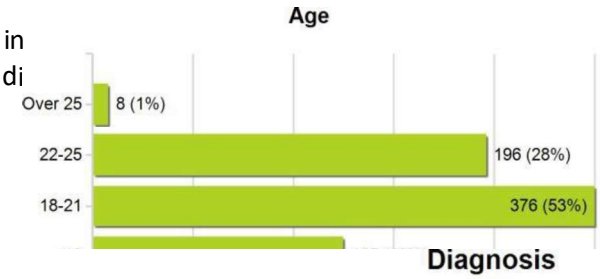
## Demographics & Diagnosis

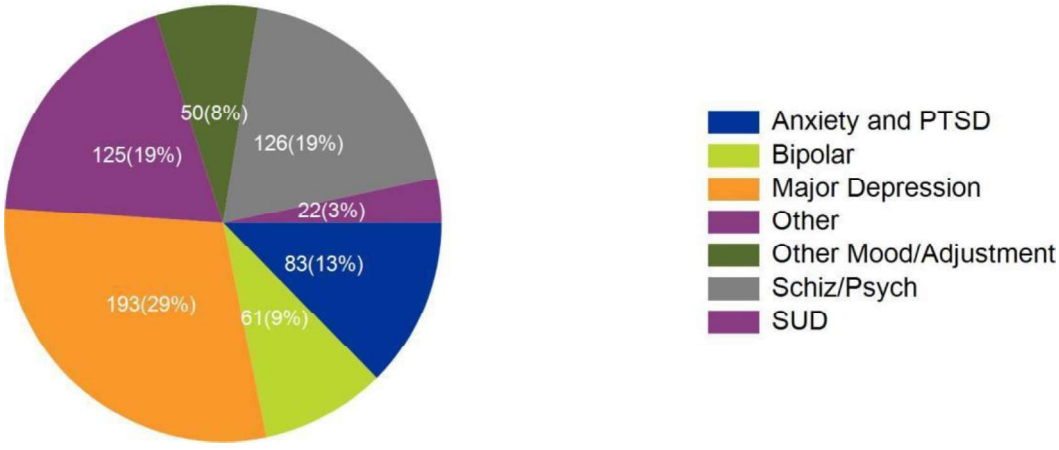
The majority served in the TAY FSP program in the 2023/2024 fiscal year were Latinx 45%, followed by Other Race, at 32%. The proportion of African American/Black participants was 9%. Also, more females (57%) have enrolled in the TAY FSP program than males (43%).




Most in (53%). A large proportion of those served were di phrenia/Psychosis disorders (19%).




## Length of FSP Partnership

The tables below show the length of stay in years for the 705 consumers enrolled in TAY FSP programs during the 2023/2024 fiscal year. The total time a consumer spent in each enrollment is included for reporting time in partnership.

The percentage of TAY with an active/open case having time in partnership longer than one year was 43%, while 63% of those without an open episode have a time in collaboration shorter than one year. Of all TAY FSP consumers served in FY 2023/2024, over two-thirds have a longer stay of less than two years (78%).

FSP re-entry: Of these **705** TAY FSP enrollments, 71 returned to an FSP program after discharging less than a year previously. These consumers are considered to have re-established partnerships, and 2 of them re-established partnerships more than once over their total time in partnership. The number of consumers who returned to an FSP program after more than a year had passed since discharging from an FSP program was 27.[4]

| TAY Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| >= 1 Year and < 2 Years | 61 | 61 | 122 | 17% |
| >= 2 Years and <3 Years | 43 | 36 | 79 | 11% |
| >= 3 Years and < 4 Years | 14 | 17 | 31 | 4% |
| >= 4 Years and < 5 years | 7 | 10 | 17 | 2% |
| >= 90 days and < 1 Year | 127 | 111 | 238 | 34% |
| >=5 Years and < 6 years | 8 | 7 | 15 | 2% |
| >=6 Years+ | 6 | 10 | 16 | 2% |
| Under 90 days | 109 | 78 | 187 | 27% |
| **Total Consumer Enrollments** | **375** | **330** | **705** | |
| **Average Years in Partnership** | 2.76 | 2.46 | 1.31 | |
| **Median Years in Partnership** | 0.64 | 0.74 | 0.70 | |
| **Maximum Years in Partnership** | 9.14 | 9.60 | 9.60 | |

Length of stay for consumers enrolled in each program is described on the following pages. The length of stay in a program includes only time enrolled in that specific program. Some consumers were enrolled in more than one program during FY 2023/2024 fiscal year or left and returned within the same fiscal year.

## Reason for Discontinuance of FSP: All TAY

Upon termination of the partnership, a reason for discontinuance is selected. For recorded cases,

[4] Active cases include those with an open episode in a TAY FSP reporting unit as of 6/30/2024. Closed cases include only those that do not have an open episode in an FSP reporting unit as of 6/30/2024. While some consumers leave the partnership and later reestablish the collaboration in the same or different FSP program, this report does not include time spent inactive.

consumers most often closed because they were Unable to Locate (36%). The next highest proportion of consumers were noted to have left the program (23%). Met Goals accounted for 21% of discontinuance reasons. Each instance was recorded in this table if a consumer terminated a partnership more than once.

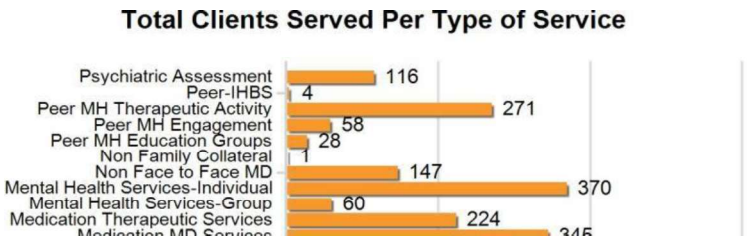
| Discontinuation Reason | Count | % |
|---|---|---|
| **Justice system** | 3 | 1% |
| **Met goals** | 73 | 21% |
| **Moved out of county/area** | 39 | 11% |
| **Needs residential care** | 8 | 2% |
| **Other** | 1 | 0% |
| **Partner cannot be located** | 122 | 36% |
| **Partner left program** | 78 | 23% |
| **Target criteria not met** | 17 | 5% |
| **Total** | **341** | **100%** |

The table below shows the number of individuals receiving various amounts of services per month for each

## Service Frequency By Month

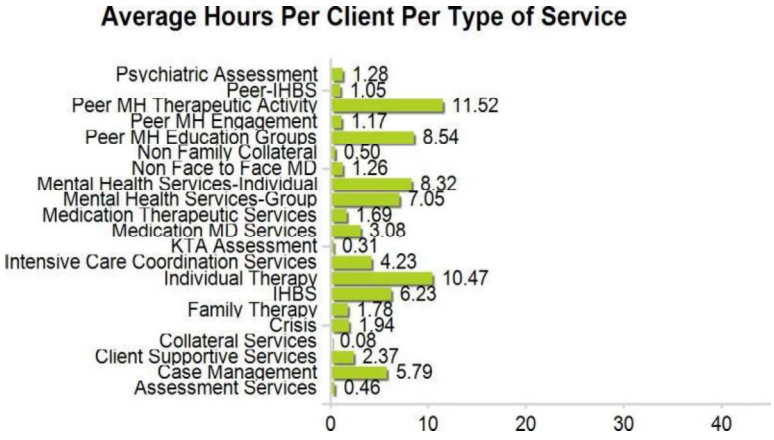
month of the 2023/2024 fiscal year. Most consumers received either 2-3 or 4-7 or more services per month within the fiscal year. On average, more than 25% of TAY FSP consumers received eight or more services per month.

| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 63 (18%) | 66 (18%) | 75 (24%) | 83 (26%) | 75 (23%) | 66 (21%) | 64 (21%) | 60 (19%) | 46 (16%) | 55 (17%) | 52 (16%) | 51 (16%) |
| 2-3 | 106 (31%) | 91 (25%) | 79 (25%) | 80 (25%) | 88 (27%) | 89 (28%) | 82 (26%) | 83 (27%) | 74 (25%) | 70 (22%) | 89 (27%) | 92 (29%) |
| 4-7 | 98 (28%) | 109 (29%) | 83 (27%) | 74 (23%) | 95 (29%) | 91 (29%) | 89 (29%) | 100 (32%) | 99 (34%) | 106 (33%) | 94 (29%) | 98 (31%) |
| 8-13 | 62 (18%) | 76 (20%) | 60 (19%) | 55 (17%) | 47 (14%) | 51 (16%) | 48 (15%) | 46 (15%) | 48 (16%) | 58 (18%) | 58 (18%) | 37 (12%) |
| 14-19 | 13 (4%) | 22 (6%) | 9 (3%) | 21 (7%) | 14 (4%) | 12 (4%) | 20 (6%) | 13 (4%) | 19 (6%) | 18 (6%) | 22 (7%) | 25 (8%) |
| 20-25 | 4 (1%) | 5 (1%) | 4 (1%) | 7 (2%) | 6 (2%) | 2 (1%) | 6 (2%) | 5 (2%) | 7 (2%) | 10 (3%) | 8 (2%) | 6 (2%) |
| 26-31 | 0 (0%) | 1 (0%) | 0 (0%) | 0 (0%) | 3 (1%) | 1 (0%) | 1 (0%) | 2 (1%) | 0 (0%) | 5 (2%) | 2 (1%) | 2 (1%) |
| 32+ | 1 (0%) | 1 (0%) | 1 (0%) | 3 (1%) | 1 (0%) | 1 (0%) | 1 (0%) | 0 (0%) | 1 (0%) | 3 (1%) | 3 (1%) | 1 (0%) |
| Monthly Total | 347 | 371 | 311 | 323 | 329 | 313 | 311 | 309 | 294 | 325 | 328 | 312 |




During the 2023/2024 Fiscal year case management, client supportive services and individual therapy were the three services that served the most consumers.

The average number of hours consumers received of each type of service while in TAY FSP programs during the 2023/2024 fiscal year was calculated. As shown to the right, the average number of hours per consumer was highest in Peer MH Therapeutic Activity (11.52 hours).

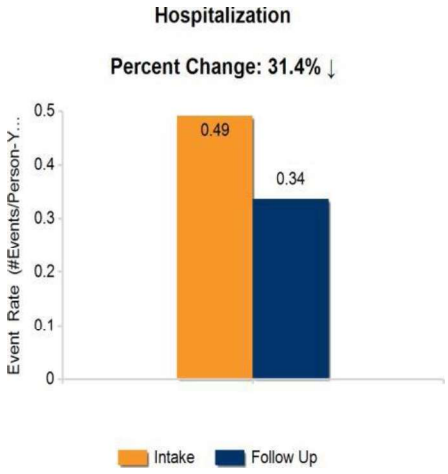



| Type of Service | # of TAY | % of TAY | # of Svcs | Avg. # Svcs |
|---|---|---|---|---|
| Assessment Services | 102 | 17% | 117 | 1.15 |
| Case Management | 436 | 74% | 6,125 | 14.05 |
| Client Supportive Services | 5 | 1% | 6 | 1.20 |
| Clinical Group | 1 | 0% | 1 | 1.00 |
| Crisis | 41 | 7% | 73 | 1.78 |
| Family Therapy | 1 | 0% | 1 | 1.00 |
| Individual Therapy | 144 | 24% | 1,068 | 7.42 |
| Medication MD Services | 309 | 52% | 953 | 3.08 |
| Medication Therapeutic Services | 339 | 57% | 3,577 | 10.55 |
| Mental Health Services-Group | 45 | 8% | 334 | 7.42 |
| Mental Health Services-Individual | 418 | 71% | 5,663 | 13.55 |
| Non Face to Face MD | 200 | 34% | 502 | 2.51 |
| Peer MH Education Groups | 35 | 6% | 181 | 5.17 |
| Peer MH Engagement | 49 | 8% | 95 | 1.94 |
| Peer MH Therapeutic Activity | 223 | 38% | 2,380 | 10.67 |
| Psychiatric Assessment | 63 | 11% | 64 | 1.02 |

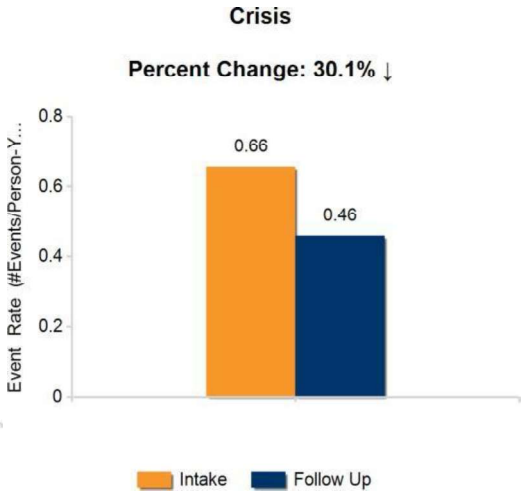
## Outcomes

Primary outcomes of interest for FSP include arrests, physical and mental health emergency room visits, incidences of acute hospitalizations, and long-term care. The number of events in the 12 months before FSP enrollment is compared with the rate of 'number of events per person-year' in the program (i.e., follow-up). At follow-up, the number of outcome events occurring while enrolled was summed and divided by the years all individuals had been in the program. Actual counts for each outcome overall and by the program can be found after page 11.

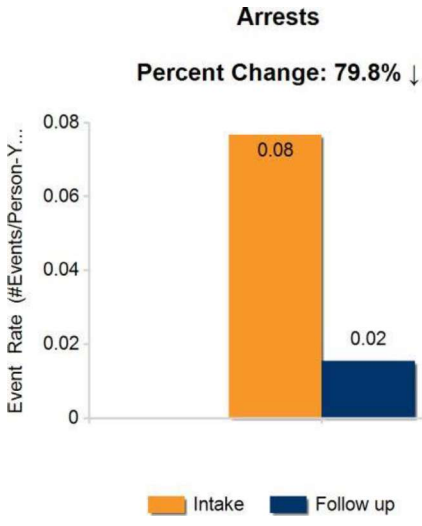
Overall, psychiatric hospitalizations, use of mental health crisis facilities, arrests, and physical health emergencies were reduced.



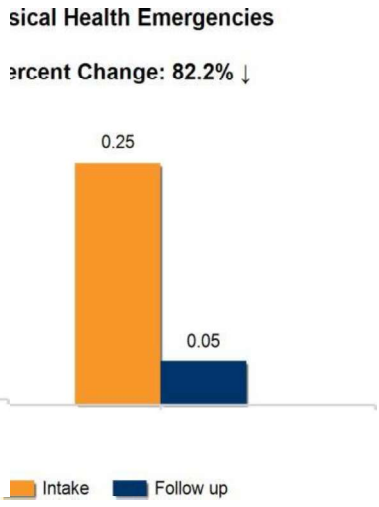

Hospitalizations decreased by 31.4% from intake to follow-up.




Crisis decreased by 30.1% from intake to follow-up.



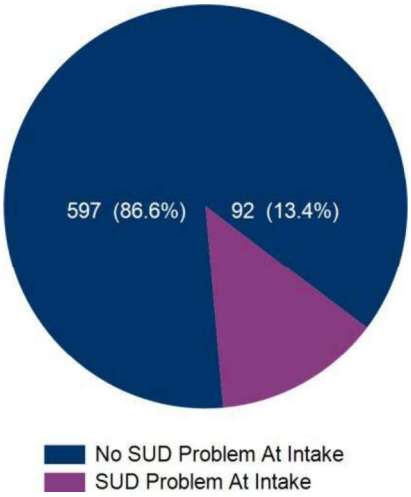

Arrests decreased by 79.8% from intake to follow-up.

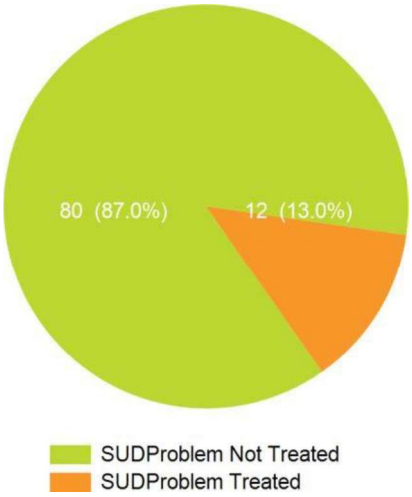



Physical Health Emergency visits decreased by 82.2%.

## Outcomes: Substance Use

Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (13.4%). The majority of those who had co-occurring MH and SU problems had not been receiving SU treatment services at intake.

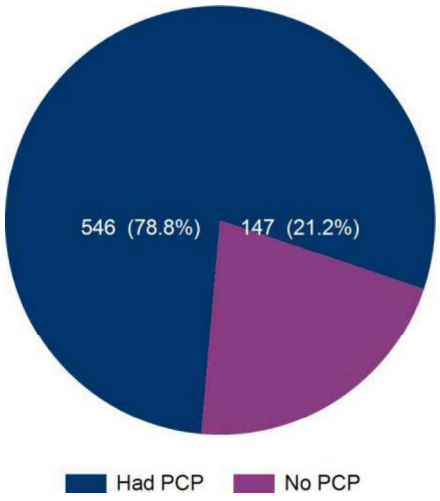



Follow-up: Based on follow-up data reported quarterly, 25.0% (20) of the 80 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 50 consumers not identified at intake were noted to have an SU problem on follow-up, and 8.0% of them were reported to be in SU services on follow-up.

## Outcomes: Primary Care Physician

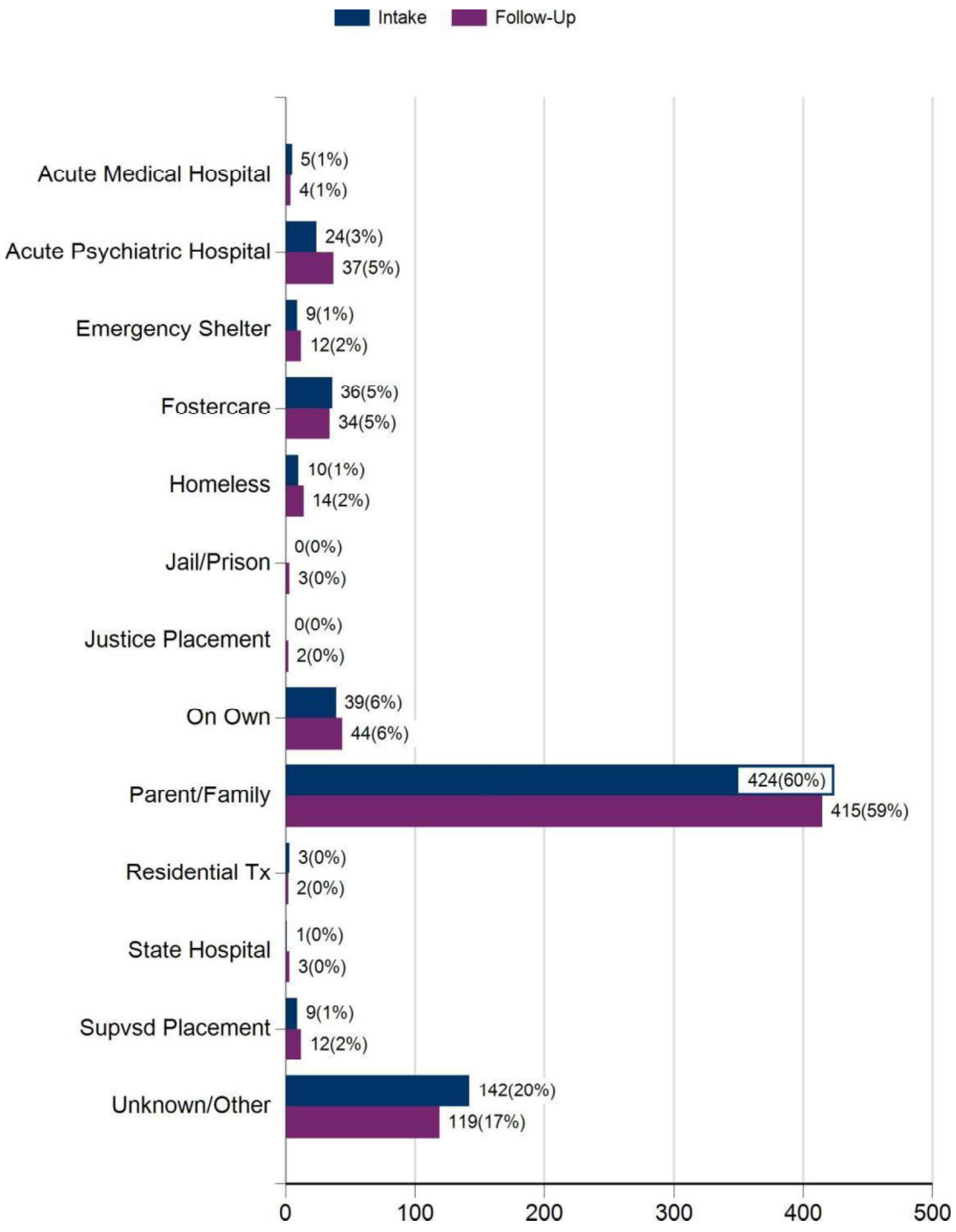
Intake: Some Consumers (21.2%) did not have a primary care physician (PCP) at intake.




Follow-up: Of the 147 consumers who did not have a PCP at intake, 79 (53.7%) obtained one while in the program.

## Outcomes: Residential

Overall, the TAY FSP consumers had a decrease in the proportion of homeless or in emergency shelters and an increase in the percentage of consumers living on their own. Residential settings were calculated using the residential category from intake to their latest residential status. The percentages below are for all reporting units.



## Outcomes: Residential Days

The following compares consumers' living arrangements in the year before FSP enrollment to their living arrangements while enrolled in the program. Specifically, the number of days spent in each setting in the year before enrollment is compared to the number of days they spent annually in each setting during enrollment. This analysis aims to determine whether days in more stable settings during FSP participation had increased and days in less stable settings had decreased.

Baseline data was obtained from consumers' Partnership Assessment Form, which includes the number of days consumers spent in each residential setting during the 12 months immediately before enrollment. Note that these 12 months preceded their **first** enrollment to any FSP program.

The number of days the consumers spent in each setting while enrolled in an FSP program was tracked through enrollment changes and residence changes noted on Key Event Tracking (KET) forms. When consumers re-enter an FSP program after a lapse in enrollment, their living arrangement is often noted on a KET form or new PAF, but if not, it is considered unknown. To accurately compare a year of pre-enrollment with a year of post-enrollment, data for residential days during enrollment has been annualized.

| | 12 Months Before Enrollment | | Annualized Days During Enrollment | | |
|---|---|---|---|---|---|
| **Living Situation** | **# of Days** | **Count (n)** | **# of Days** | **Count (n)** | **Percent change (%)** |
| | 0 | 0 | 23,556 | 101 | 0% |
| Acute Medical Hospital | 205 | 27 | 663 | 19 | 223% |
| Acute Psychiatric Hospital | 1,903 | 108 | 5,324 | 98 | 180% |
| Community Treatment Facility | 395 | 3 | - | 1 | -100% |
| Emergency Shelter | 1,999 | 19 | 4,821 | 24 | 141% |
| Fostercare | 4,210 | 15 | 4,108 | 13 | -2% |
| Homeless | 4,588 | 23 | 2,872 | 20 | -37% |
| Jail/Prison | 281 | 10 | 460 | 7 | 64% |
| Justice Placement | 129 | 4 | 17 | 1 | -87% |
| On Own | 13,062 | 46 | 18,906 | 67 | 45% |
| Parent/Family | 160,914 | 481 | 170,371 | 504 | 6% |
| Residential Tx | 544 | 22 | 5,705 | 28 | 949% |
| State Hospital | 33 | 3 | 146 | 4 | 342% |
| Supervised Placement | 2,175 | 16 | 6,547 | 13 | 201% |
| Unknown/Other | 66,887 | 187 | 6,694 | 78 | -90% |

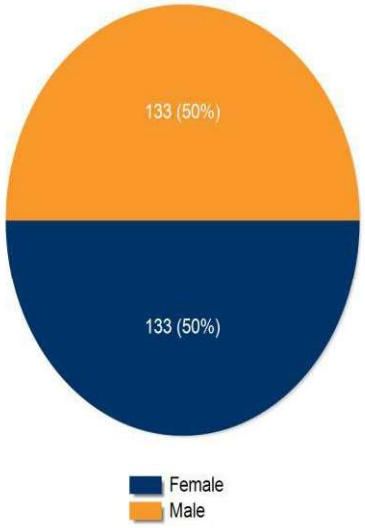
**FSP TAY demographics and Outcomes for:**
**33G2FT Served by this reporting unit: 261**

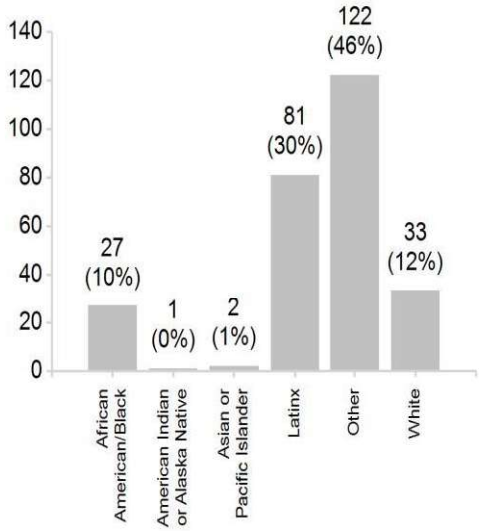
**Demographics**

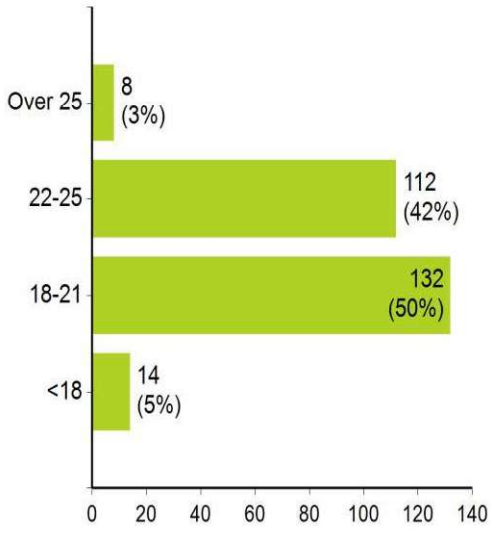
50% of consumers were male and 50% were female.

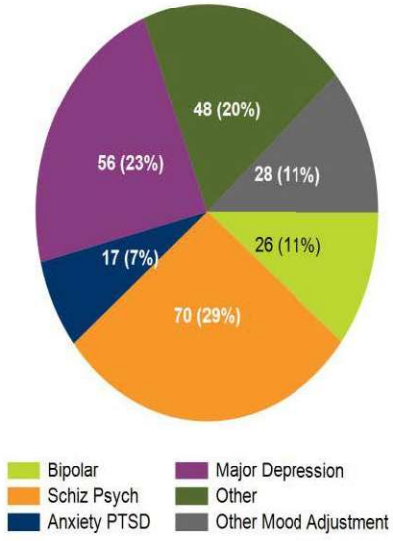
12% of consumers were White, 30% were Latinx, and 10% were Black/African American.

50% of consumers were 18 to 21 years old.



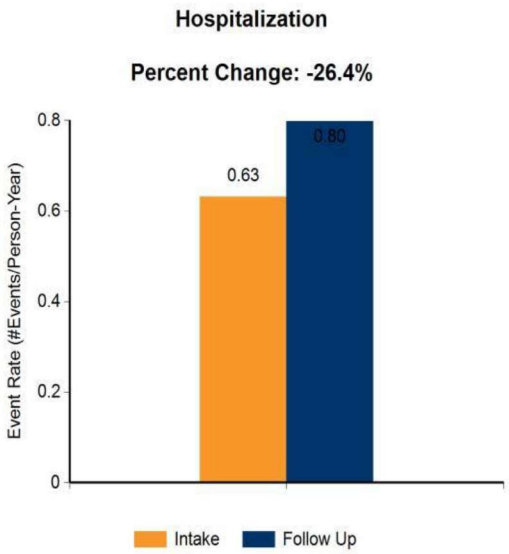



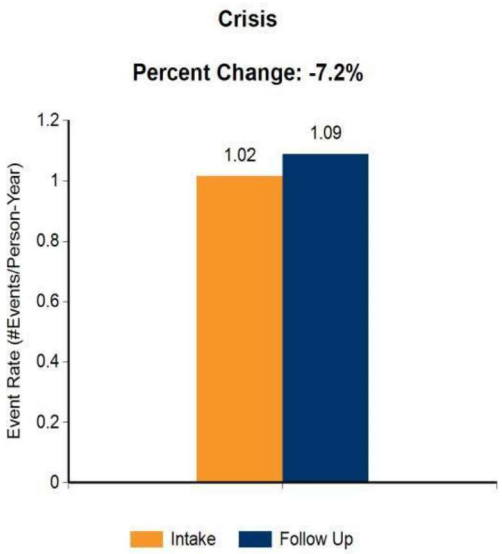



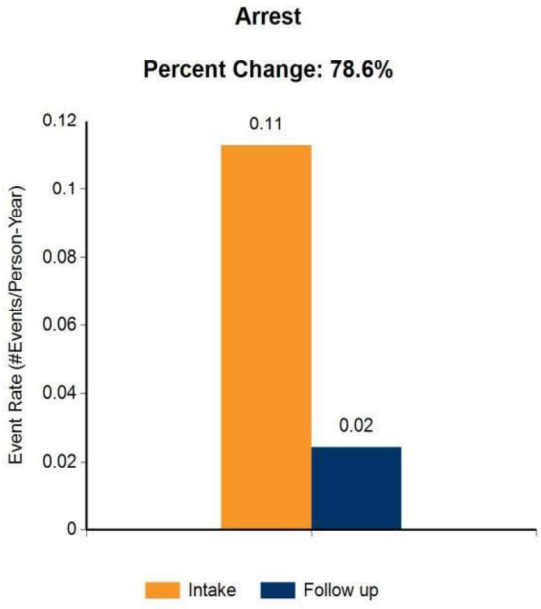



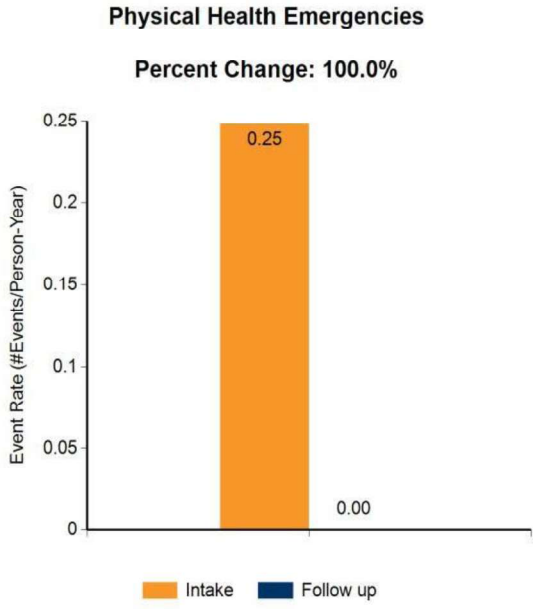
## Outcomes for 33G2FT

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

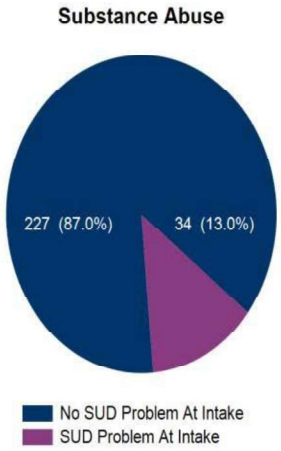


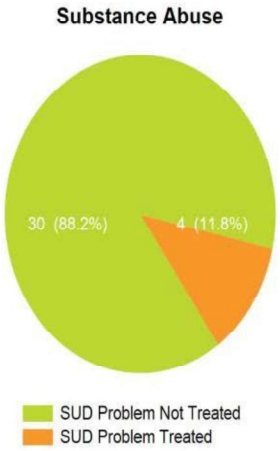



## Outcomes: Substance Use (33G2FT)

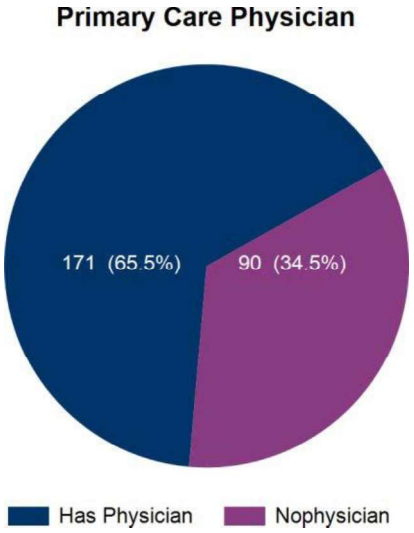



Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (13.0%). The majority of those who had co-occurring MH and SU problems had not been receiving SU treatment services at intake.

Follow-up: Based on quarterly follow-up data, 23.3% (7) of the 30 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 16 consumers not identified at intake were noted to have an SU problem on follow-up, and 13.0% were reported to be in SU services on follow-up.

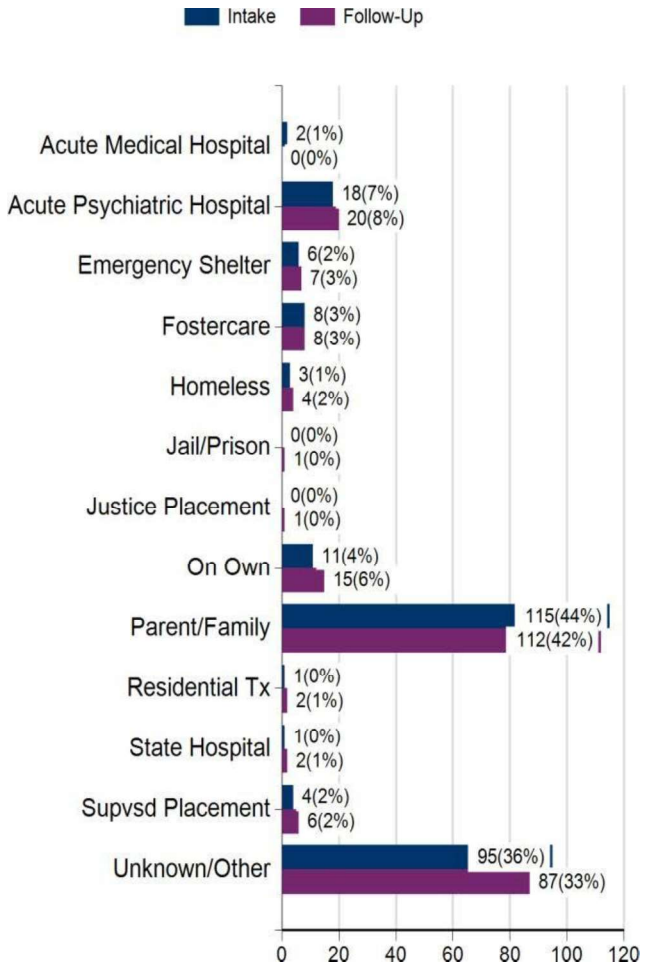
## Outcomes: Primary Care Physician (33G2FT)




Intake: Most consumers (34.5%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 90 consumers who did not have a PCP at intake, 37 (41.0%) obtained one while in the program.

## Outcomes: Residential & Discontinuance (33G2FT)




| Discontinuation Reason | Count | % |
|---|---|---|
| Justice system | 2 | 1% |
| Met goals | 26 | 15% |
| Moved out of county/area | 19 | 11% |
| Needs residential care | 1 | 1% |
| Other | 1 | 1% |
| Partner cannot be located | 69 | 41% |
| Partner left program | 48 | 29% |
| Target criteria not met | 2 | 1% |
| **Total** | **168** | **100%** |

## Length of FSP Partnership for: 33G2FT

| TAY Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| >= 1 Year and < 2 Years | 21 | 20 | 41 | 15.41% |
| >= 2 Years and <3 Years | 9 | 7 | 16 | 6.02% |
| >= 3 Years and < 4 Years | 5 | 3 | 8 | 3.01% |
| >= 4 Years and < 5 years | 2 | 1 | 3 | 1.13% |
| >= 90 days and < 1 Year | 44 | 22 | 66 | 24.81% |
| >=5 Years and < 6 years | 2 | 2 | 4 | 1.50% |
| >=6 Years+ | 1 | 5 | 6 | 2.26% |
| Under 90 days | 85 | 37 | 122 | 45.86% |
| **Total Consumer Enrollments** | **169** | **97** | **266** | |

## Service Detail: 33G2FT

| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 30 (32%) | 29 (25%) | 32 (50%) | 48 (61%) | 39 (47%) | 27 (33%) | 31 (37%) | 20 (27%) | 14 (19%) | 17 (18%) | 17 (17%) | 23 (24%) |
| 2-3 | 36 (38%) | 37 (32%) | 21 (33%) | 22 (28%) | 25 (30%) | 28 (35%) | 26 (31%) | 22 (29%) | 21 (29%) | 20 (21%) | 26 (26%) | 26 (27%) |
| 4-7 | 20 (21%) | 37 (32%) | 9 (14%) | 8 (10%) | 16 (19%) | 21 (26%) | 21 (25%) | 20 (27%) | 20 (28%) | 37 (39%) | 30 (30%) | 29 (31%) |
| 8-13 | 8 (8%) | 10 (9%) | 2 (3%) | 0 (0%) | 2 (2%) | 5 (6%) | 3 (4%) | 9 (12%) | 10 (14%) | 17 (18%) | 18 (18%) | 10 (11%) |
| 14-19 | 1 (1%) | 2 (2%) | 0 (0%) | 0 (0%) | 1 (1%) | 0 (0%) | 1 (1%) | 2 (3%) | 6 (8%) | 2 (2%) | 6 (6%) | 6 (6%) |
| 20-25 | 0 (0%) | 0 (0%) | 0 (0%) | 1 (1%) | 0 (0%) | 0 (0%) | 1 (1%) | 1 (1%) | 0 (0%) | 2 (2%) | 1 (1%) | 1 (1%) |
| 26-31 | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (1%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| 32+ | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (1%) | 0 (0%) | 2 (2%) | 0 (0%) |
| Monthly Total | 95 | 115 | 64 | 79 | 83 | 81 | 83 | 75 | 72 | 95 | 100 | 95 |

| Type of Service | % of TAY | # of Svcs | Avg. # Svcs |
|---|---|---|---|

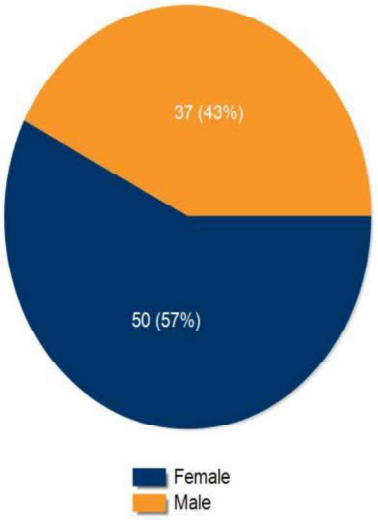
**FSP TAY demographics and Outcomes for:**
**33H6FT Served by this reporting unit: 85**
**Enrollment: 87**

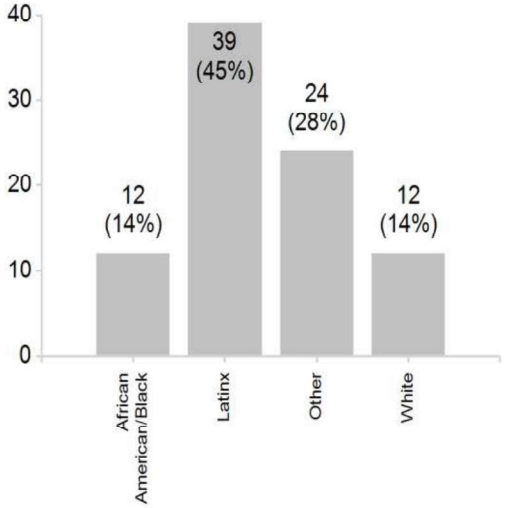
## Demographics

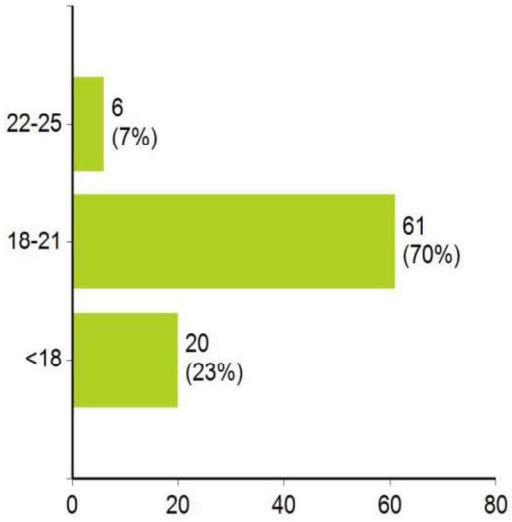
43% of consumers were male and 57% were female.

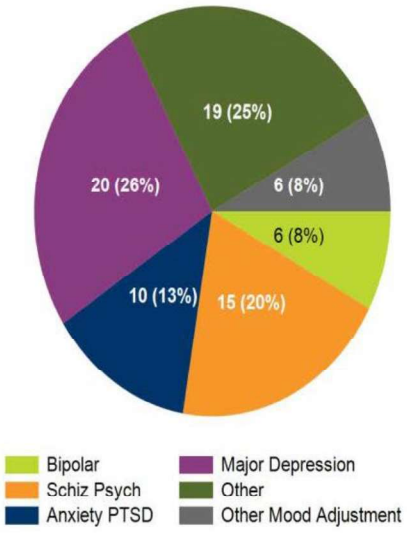
14% of consumers were White, 45% were Latinx, and 14% were Black/African American.

70% of consumers were 18 to 21 years old.



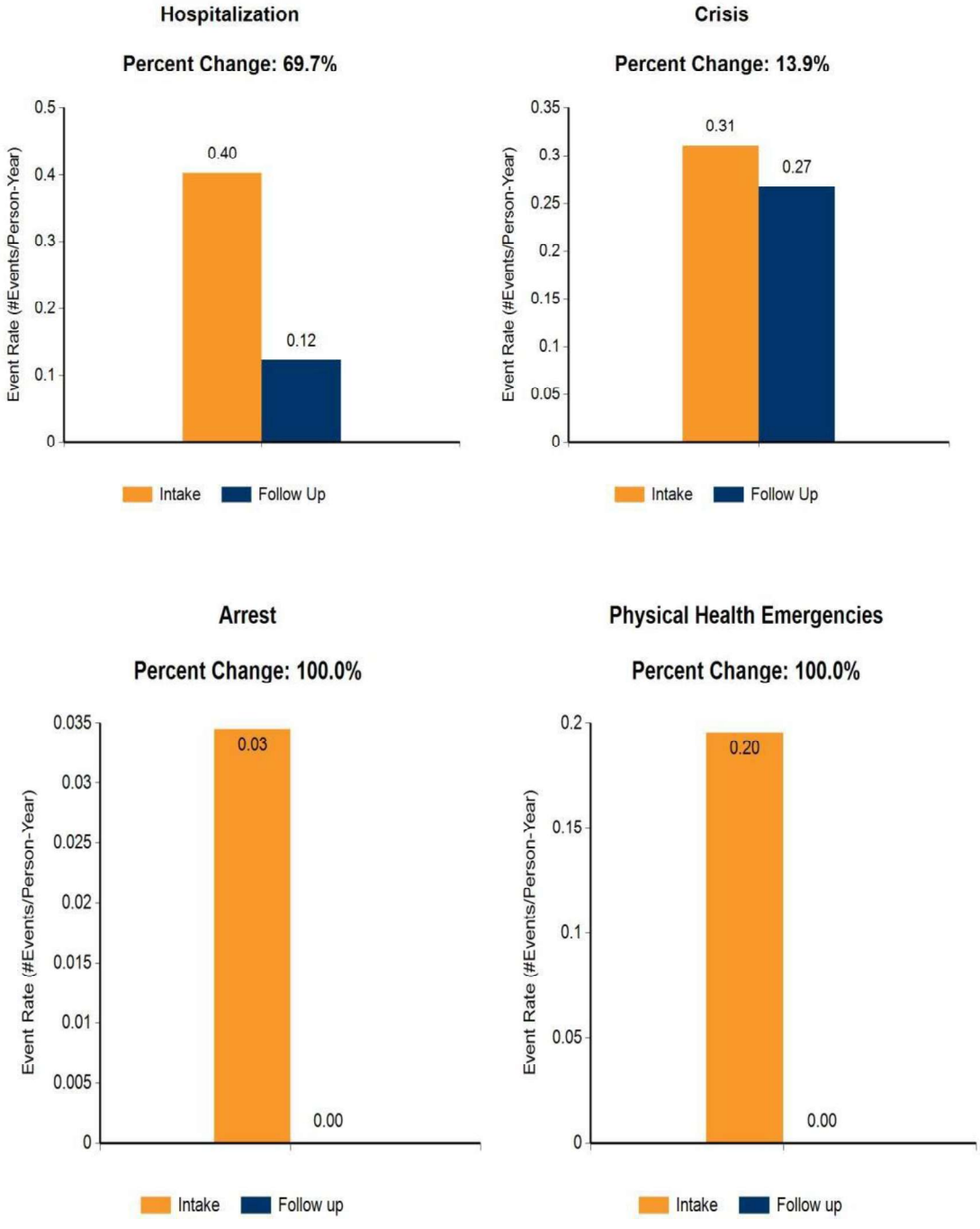



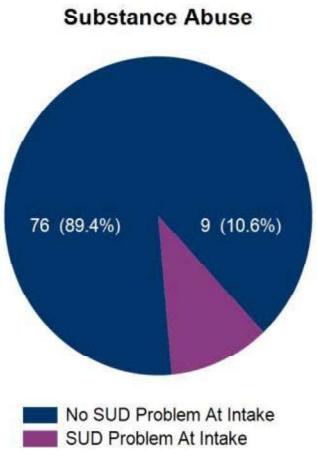
## Outcomes for 33H6FT

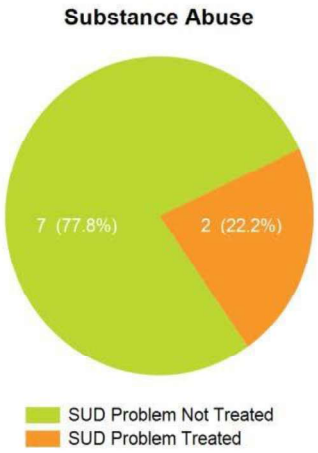
Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.



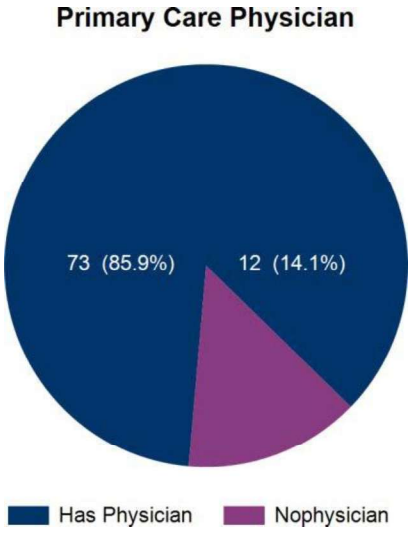

Intake: a significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) issues (10.6%). The majority of those with co-occurring MH and SU problems had not been receiving SU treatment services at intake.

## Outcomes: Substance Use (33H6FT)



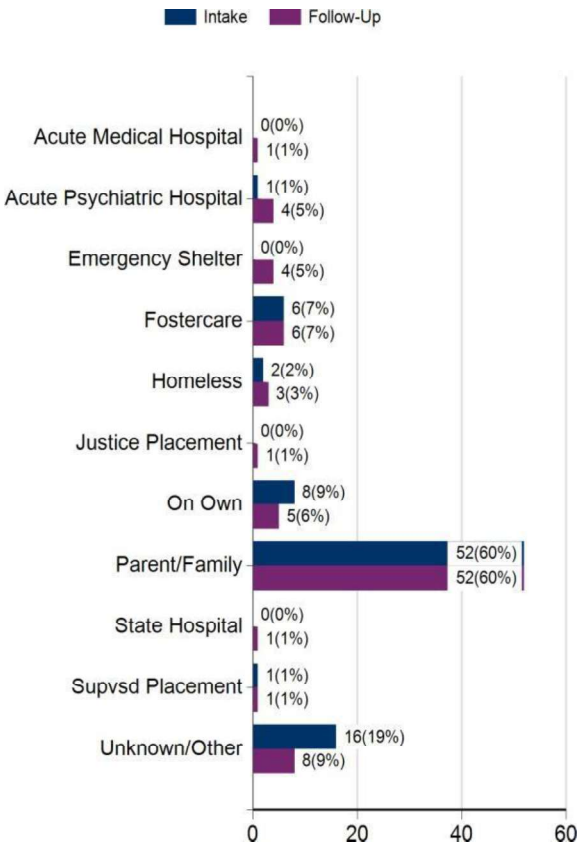

Follow-up: Based on quarterly follow-up data, 42.9% (3) of the 7 individuals with a co-occurring problem and no participation in SU services at intake were now involved in SU services. Additionally, 3 consumers who were not identified at intake were found to have an SU issue during follow-up, and 0.0% of them were reported to be in SU services on follow-up.




Intake: Most consumers (14.1%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 12 consumers who did not have a PCP at intake, 12 (100.0%) obtained one while in the program.

## Outcomes: Residential & Discontinuance (33H6FT)




| Discontinuation Reason | Count | % |
|---|---|---|
| Justice system | 1 | 2% |
| Met goals | 25 | 45% |
| Moved out of county/area | 7 | 13% |
| Partner cannot be located | 8 | 14% |
| Partner left program | 7 | 13% |
| Target criteria not met | 8 | 14% |
| **Total** | **56** | **100%** |

## Length of FSP Partnership for: 33H6FT

| TAY Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| >= 1 Year and < 2 Years | 13 | 4 | 17 | 19.54% |
| >= 2 Years and <3 Years | 10 | 2 | 12 | 13.79% |
| >= 3 Years and < 4 Years | 5 | 2 | 7 | 8.05% |
| >= 4 Years and < 5 years | 3 | 3 | 6 | 6.90% |
| >= 90 days and < 1 Year | 14 | 16 | 30 | 34.48% |
| >=5 Years and < 6 years | 4 | 0 | 4 | 4.60% |
| >=6 Years+ | 3 | 0 | 3 | 3.45% |
| Under 90 days | 4 | 4 | 8 | 9.20% |
| **Total Consumer Enrollments** | **56** | **31** | **87** | |

## Service Detail: 33H6FT

| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 5 (8%) | 2 (3%) | 2 (4%) | 0 (0%) | 5 (9%) | 1 (2%) | 2 (4%) | 2 (4%) | 2 (5%) | 2 (5%) | 3 (8%) | 1 (3%) |
| 2-3 | 5 (8%) | 6 (10%) | 5 (9%) | 8 (15%) | 6 (11%) | 9 (17%) | 10 (19%) | 10 (21%) | 7 (16%) | 5 (13%) | 3 (8%) | 2 (6%) |
| 4-7 | 19 (32%) | 12 (21%) | 17 (30%) | 12 (22%) | 16 (29%) | 16 (30%) | 14 (26%) | 15 (32%) | 10 (23%) | 5 (13%) | 9 (25%) | 8 (24%) |
| 8-13 | 25 (42%) | 28 (48%) | 25 (44%) | 20 (36%) | 18 (32%) | 19 (36%) | 16 (30%) | 15 (32%) | 14 (32%) | 17 (43%) | 9 (25%) | 8 (24%) |
| 14-19 | 4 (7%) | 7 (12%) | 6 (11%) | 9 (16%) | 5 (9%) | 6 (11%) | 6 (11%) | 3 (6%) | 7 (16%) | 5 (13%) | 7 (19%) | 8 (24%) |
| 20-25 | 1 (2%) | 2 (3%) | 1 (2%) | 3 (5%) | 2 (4%) | 0 (0%) | 4 (7%) | 1 (2%) | 4 (9%) | 4 (10%) | 4 (11%) | 3 (9%) |
| 26-31 | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 3 (5%) | 1 (2%) | 1 (2%) | 1 (2%) | 0 (0%) | 2 (5%) | 1 (3%) | 2 (6%) |
| 32+ | 1 (2%) | 1 (2%) | 1 (2%) | 3 (5%) | 1 (2%) | 1 (2%) | 1 (2%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (3%) |
| Monthly Total | 60 | 58 | 57 | 55 | 56 | 53 | 54 | 47 | 44 | 40 | 36 | 33 |

| Type of Service | % of TAY | # of Svcs | Avg. # Svcs |
|---|---|---|---|

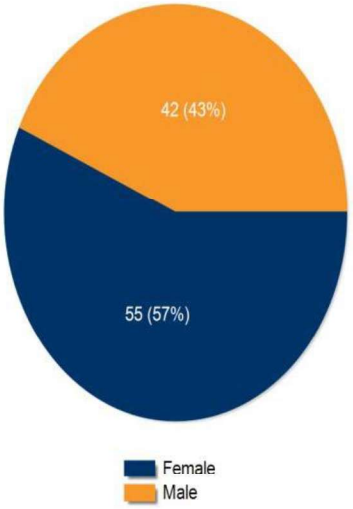
**FSP TAY demographics and Outcomes for: 33HWFT Served by this reporting unit: 95**

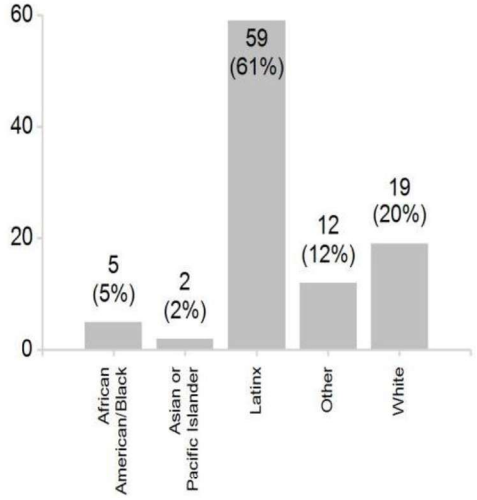
**Demographics**

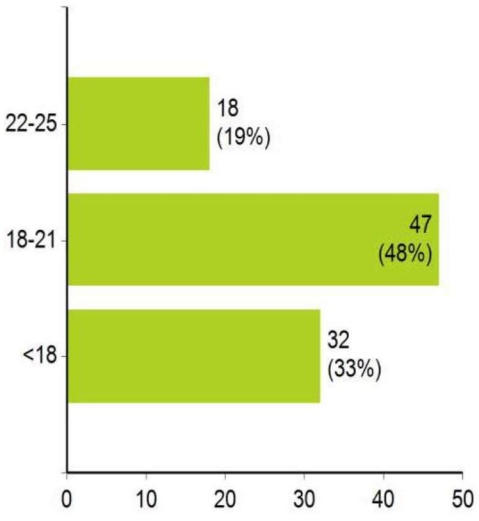
43% of consumers were male and 57% were female.

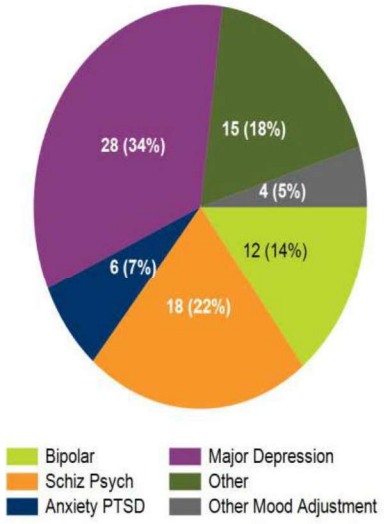
20% of consumers were White, 61% of consumers were Latinx and 5% of consumers were Black/African American.

48% of consumers were 18 to 21 years old.



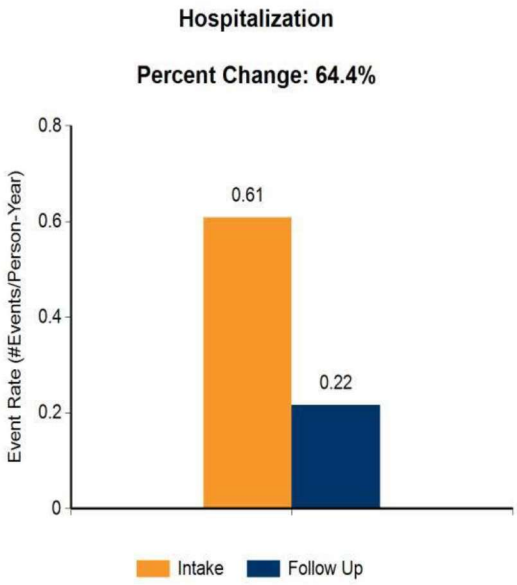



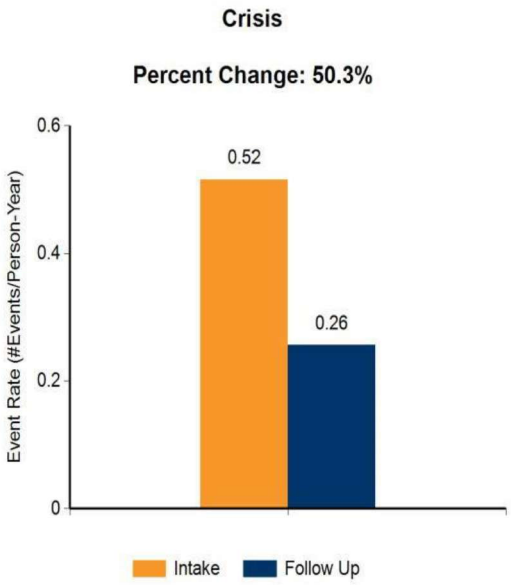



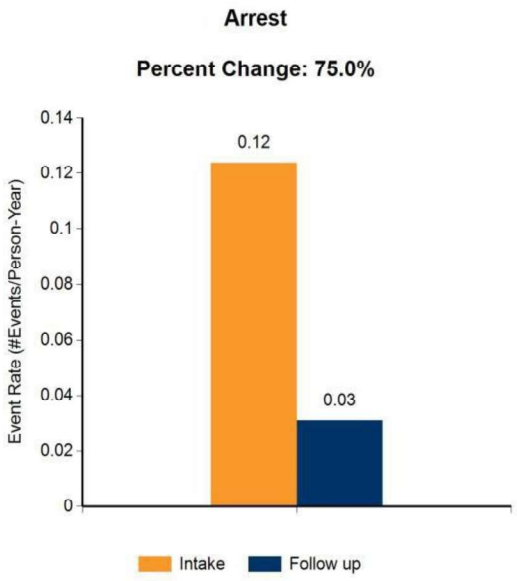



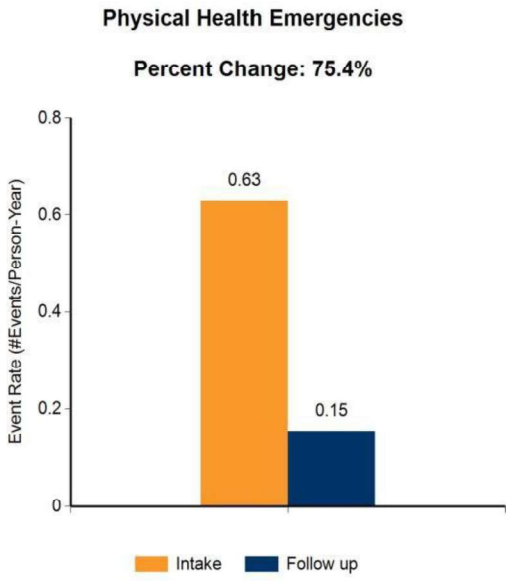
## Outcomes for 33HWFT

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

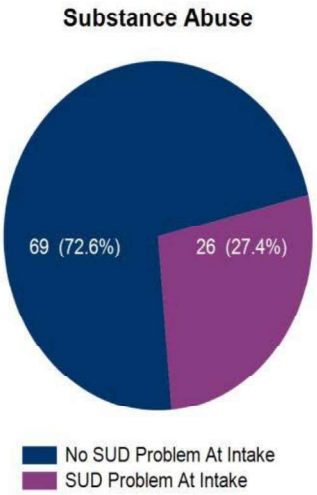


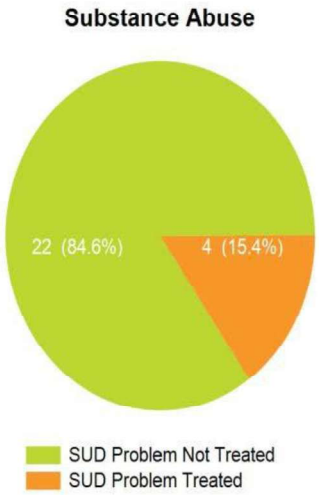



## Outcomes: Substance Use (33HWFT)

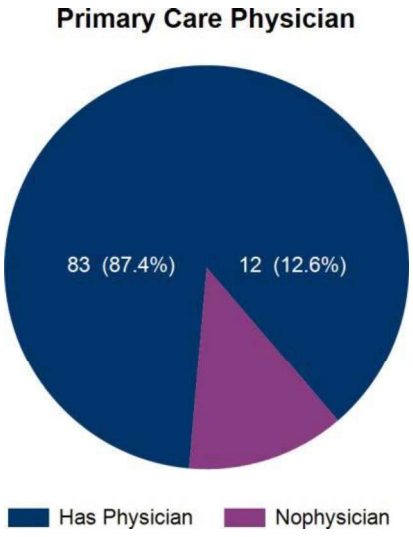



Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (27.4%). The majority of those who had co-occurring MH and SU problems had not been receiving SU treatment services at intake.

Follow-up: Based on quarterly follow-up data, 31.8% (7) of the 22 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 13 consumers not identified at intake were noted to have an SU problem on follow-up, and 8.0% were reported to be in SU services on follow-up.

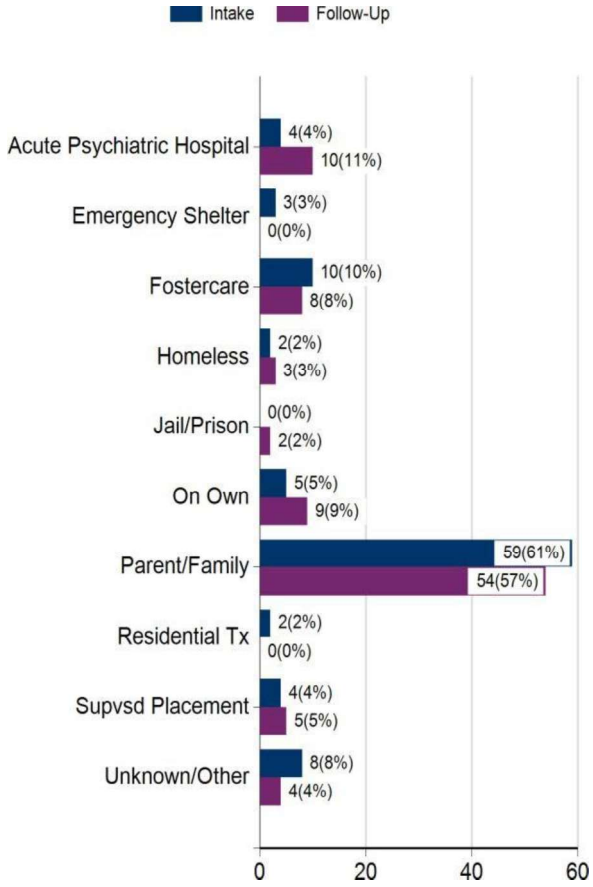
## Outcomes: Primary Care Physician (33HWFT)




Intake: Most consumers (12.6%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 12 consumers that did not have a PCP at intake, 11 (92.0%) obtained a PCP while in the program.

## Outcomes: Residential & Discontinuance (33HWFT)




| Discontinuation Reason | Count | % |
|---|---|---|
| Met goals | 6 | 18% |
| Moved out of county/area | 8 | 24% |
| Needs residential care | 1 | 3% |
| Partner cannot be located | 7 | 21% |
| Partner left program | 9 | 26% |
| Target criteria not met | 3 | 9% |
| **Total** | **34** | **100%** |

## Service Detail:33HWFT

| TAY Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| >= 1 Year and < 2 Years | 9 | 10 | 19 | 61.29% |
| >= 2 Years and <3 Years | 4 | 9 | 13 | 41.94% |
| >= 3 Years and < 4 Years | 3 | 4 | 7 | 22.58% |
| >= 4 Years and < 5 years | 2 | 6 | 8 | 25.81% |
| >= 90 days and < 1 Year | 12 | 14 | 26 | 83.87% |
| >=5 Years and < 6 years | 2 | 5 | 7 | 22.58% |
| >=6 Years+ | 2 | 5 | 7 | 22.58% |
| Under 90 days | 0 | 10 | 10 | 32.26% |
| **Total Consumer Enrollments** | **34** | **63** | **97** | |

## Length of FSP Partnership for: 33HWFT

| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 11 (17%) | 10 (19%) | 17 (32%) | 11 (23%) | 3 (7%) | 9 (19%) | 5 (10%) | 9 (16%) | 9 (17%) | 9 (18%) | 4 (7%) | 4 (7%) |
| 2-3 | 25 (38%) | 16 (30%) | 16 (30%) | 13 (27%) | 12 (26%) | 14 (29%) | 13 (27%) | 18 (33%) | 11 (21%) | 9 (18%) | 18 (32%) | 16 (29%) |
| 4-7 | 23 (35%) | 17 (31%) | 12 (23%) | 16 (33%) | 24 (52%) | 12 (25%) | 15 (31%) | 16 (29%) | 23 (43%) | 14 (28%) | 16 (28%) | 26 (46%) |
| 8-13 | 5 (8%) | 9 (17%) | 8 (15%) | 4 (8%) | 4 (9%) | 10 (21%) | 15 (31%) | 9 (16%) | 6 (11%) | 6 (12%) | 11 (19%) | 3 (5%) |
| 14-19 | 1 (2%) | 2 (4%) | 0 (0%) | 4 (8%) | 2 (4%) | 3 (6%) | 1 (2%) | 3 (5%) | 4 (8%) | 5 (10%) | 5 (9%) | 5 (9%) |
| 20-25 | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (2%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 2 (4%) | 3 (5%) | 2 (4%) |
| 26-31 | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 3 (6%) | 0 (0%) | 0 (0%) |
| 32+ | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 2 (4%) | 0 (0%) | 0 (0%) |
| Monthly Total | 65 | 54 | 53 | 48 | 46 | 48 | 49 | 55 | 53 | 50 | 57 | 56 |

| Type of Service | % of TAY | # of Svcs | Avg. # Svcs |
|---|---|---|---|

34 % of consumers were male and 66% were female.

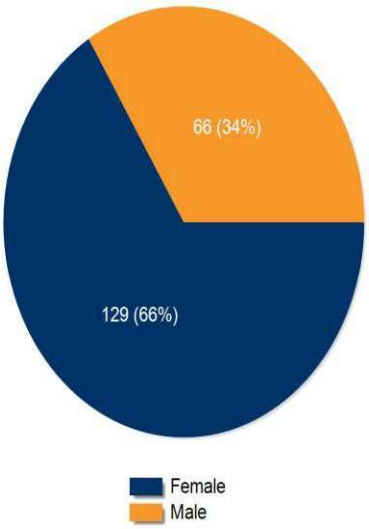
7% of consumers were White, 57% of consumers were Latinx and 8% of consumers were Black/African American.

54% of consumers were 18 to 21 years old.

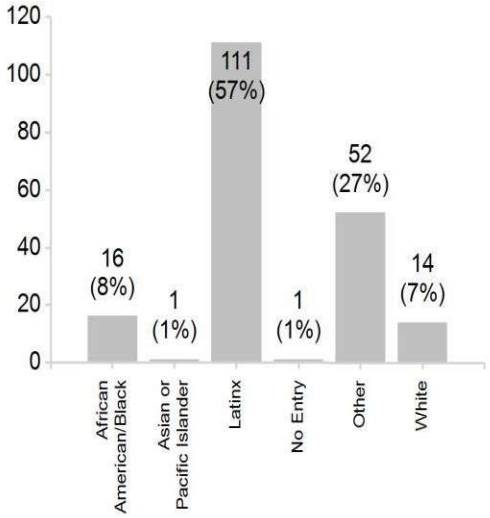
**FSP TAY demographics and Outcomes for:**
**33O2FT Served by this reporting unit: 192**
**Enrollment: 195**

## Demographics

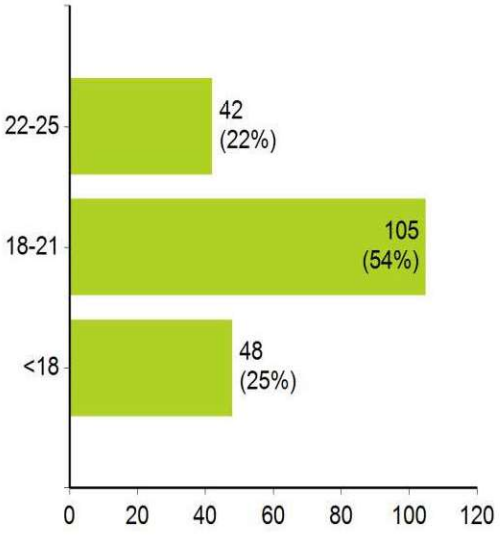
### Gender



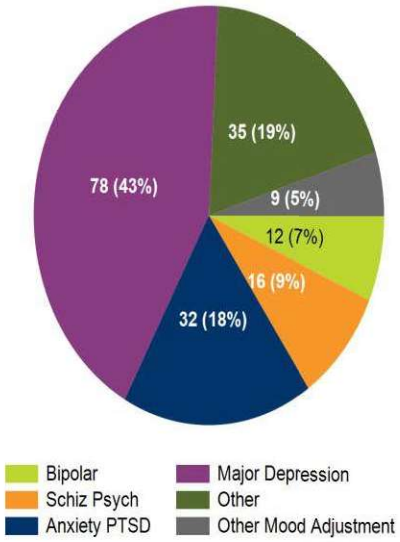

### Race/Ethnicity




### Age

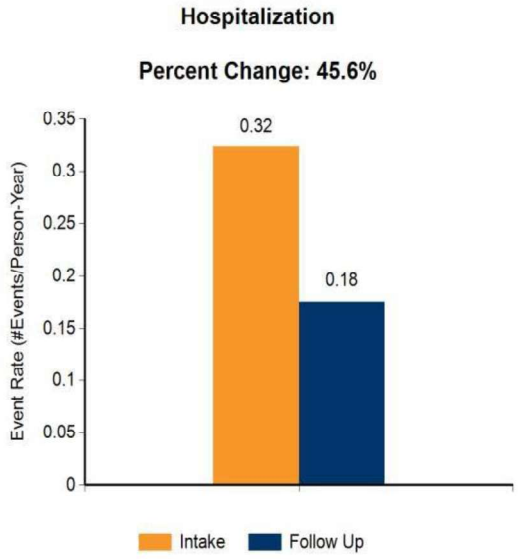


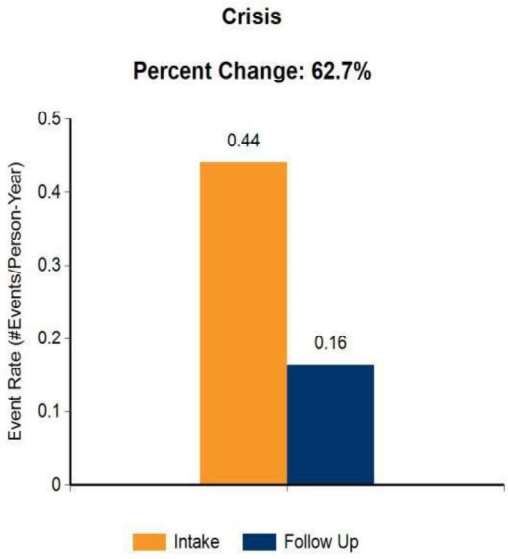

### Diagnosis

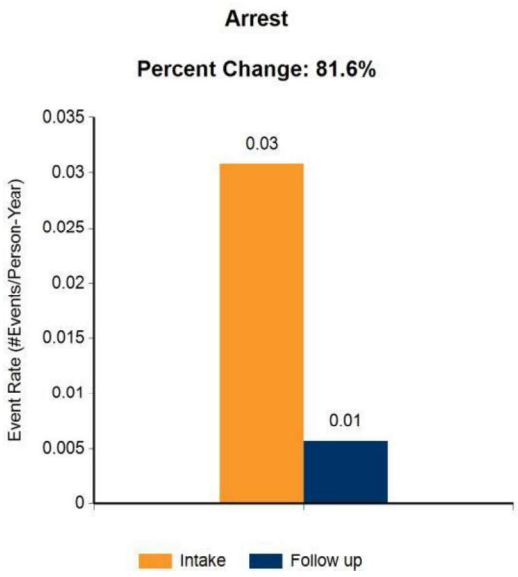


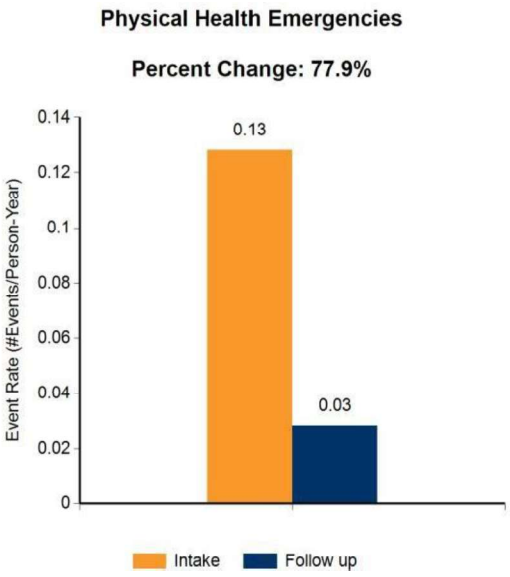
## Outcomes for 33O2FT

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

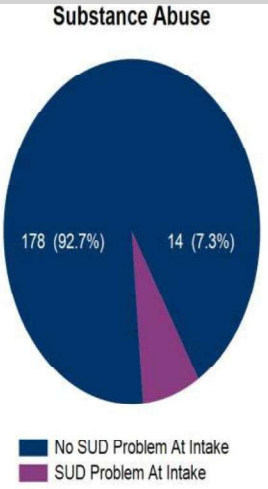


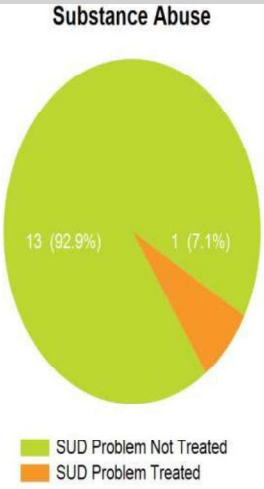



## Outcomes: Substance Use (33O2FT)

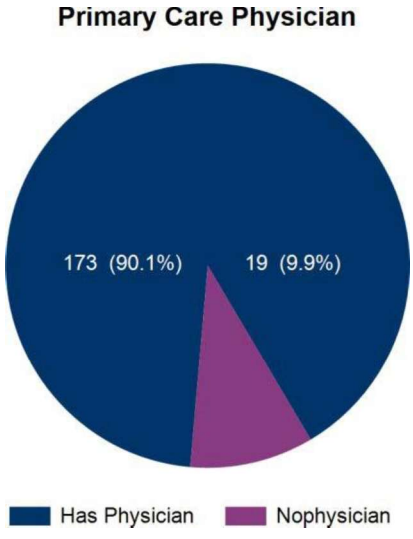



Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (7.3%). The majority of those who had co-occurring MH and SU problems had not been receiving SU treatment services at intake.

Follow-up: Based on quarterly follow-up data, 7.7% (1) of the 13 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 14 consumers not identified at intake were noted to have an SU problem on follow-up and 7.0% were reported to be in SU services on follow-up.

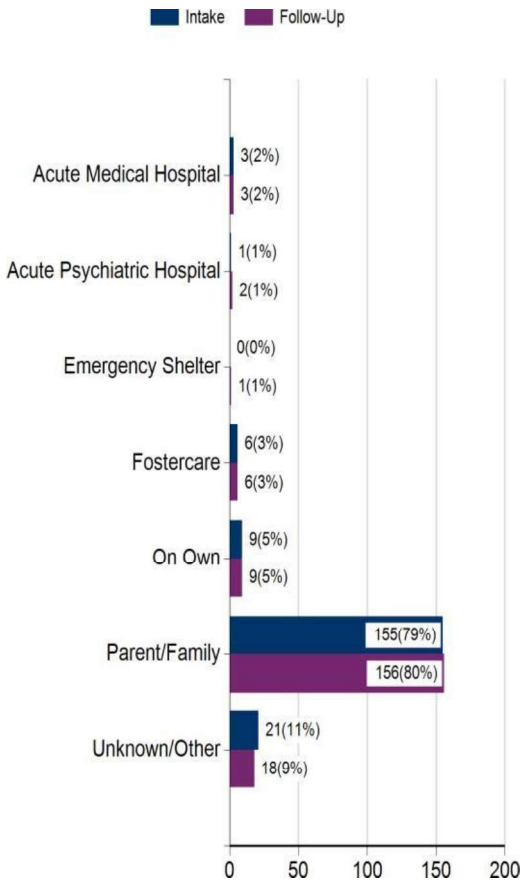
## Outcomes: Primary Care Physician (33O2FT)




Intake: Most consumers (9.9%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 19 consumers that did not have a PCP at intake, 14 (74.0%) obtained a PCP while in the program.

## Outcomes: Residential & Discontinuance (33O2FT)




| Discontinuation Reason | Count | % |
|---|---|---|
| Met goals | 14 | 19% |
| Moved out of county/area | 5 | 7% |
| Needs residential care | 6 | 8% |
| Partner cannot be located | 34 | 47% |
| Partner left program | 13 | 18% |
| Target criteria not met | 1 | 1% |
| **Total** | **73** | **100%** |

## Length of FSP Partnership for: 33O2FT

| TAY Time in Partnership |
|---|
| >= 1 Year and < 2 Years |
| >= 2 Years and <3 Years |
| >= 3 Years and < 4 Years |
| >= 90 days and < 1 Year |

Under 90 days

**Total Consumer Enrollments**

| Closed | Open | All Consumers | % of Total |
|---|---|---|---|
| 11 | 20 | 31 | 15.90% |
| 9 | 15 | 24 | 12.31% |
| 0 | 4 | 4 | 2.05% |
| 44 | 55 | 99 | 50.77% |
| 17 | 20 | 37 | 18.97% |
| **81** | **114** | **195** | |

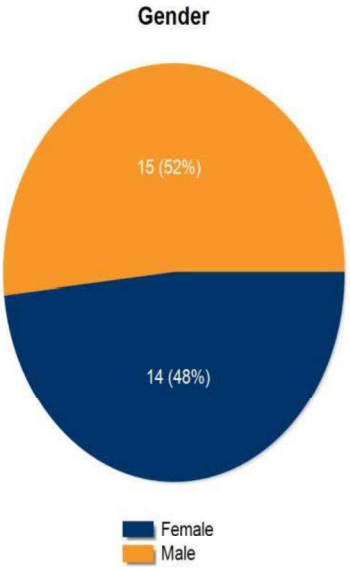
## Service Detail: 33O2FT

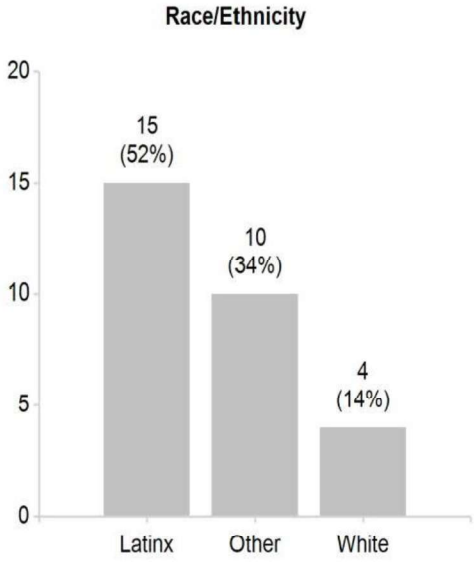
| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 10 (11%) | 14 (13%) | 19 (18%) | 21 (19%) | 23 (21%) | 27 (26%) | 22 (23%) | 21 (20%) | 19 (18%) | 22 (19%) | 22 (20%) | 20 (20%) |
| 2-3 | 21 (23%) | 22 (21%) | 26 (25%) | 31 (29%) | 28 (26%) | 25 (24%) | 25 (26%) | 27 (25%) | 31 (30%) | 30 (26%) | 37 (34%) | 38 (37%) |
| 4-7 | 26 (29%) | 29 (28%) | 34 (33%) | 28 (26%) | 31 (29%) | 35 (34%) | 28 (29%) | 42 (39%) | 40 (38%) | 39 (34%) | 31 (29%) | 29 (28%) |
| 8-13 | 24 (27%) | 24 (23%) | 19 (18%) | 20 (19%) | 18 (17%) | 13 (13%) | 12 (13%) | 12 (11%) | 10 (10%) | 17 (15%) | 15 (14%) | 11 (11%) |
| 14-19 | 6 (7%) | 11 (11%) | 2 (2%) | 5 (5%) | 5 (5%) | 2 (2%) | 8 (8%) | 3 (3%) | 2 (2%) | 6 (5%) | 2 (2%) | 4 (4%) |
| 20-25 | 3 (3%) | 3 (3%) | 3 (3%) | 3 (3%) | 2 (2%) | 1 (1%) | 1 (1%) | 2 (2%) | 2 (2%) | 1 (1%) | 0 (0%) | 0 (0%) |
| 26-31 | 0 (0%) | 1 (1%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| 32+ | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (1%) | 1 (1%) | 0 (0%) |
| Monthly Total | 90 | 104 | 103 | 108 | 107 | 103 | 96 | 107 | 104 | 116 | 108 | 102 |

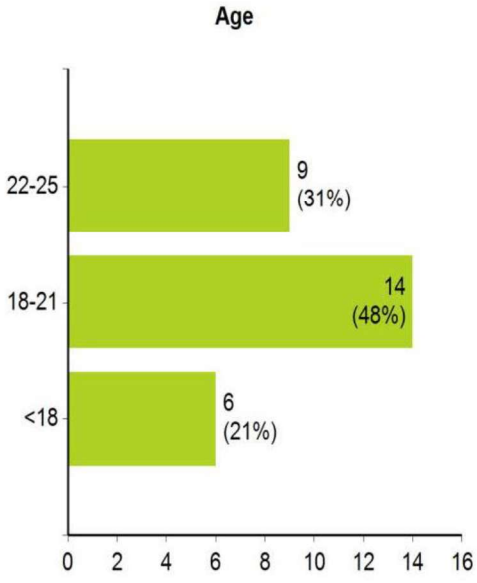
**FSP TAY demographics and Outcomes for:**
**33OPFT Served by this reporting unit: 29**
**Enrollment: 29**

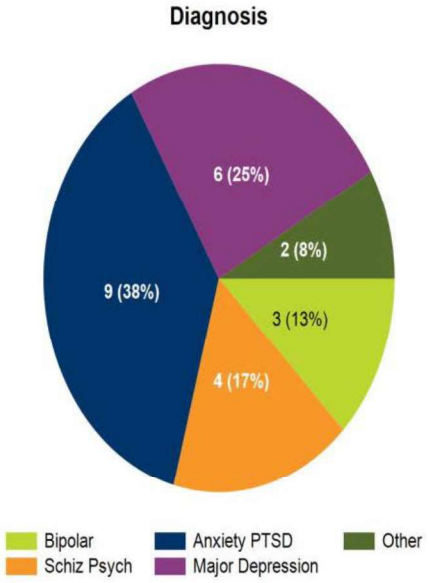
## Demographics

52% of consumers identified as male, while 48% identified as female.
14% of consumers were White, 52% were Latinx, and 0% were Black or African American.
48% of consumers were aged 18 to 21 years old.



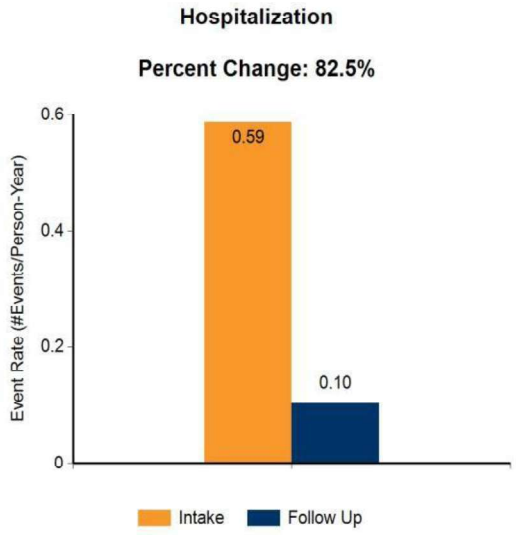



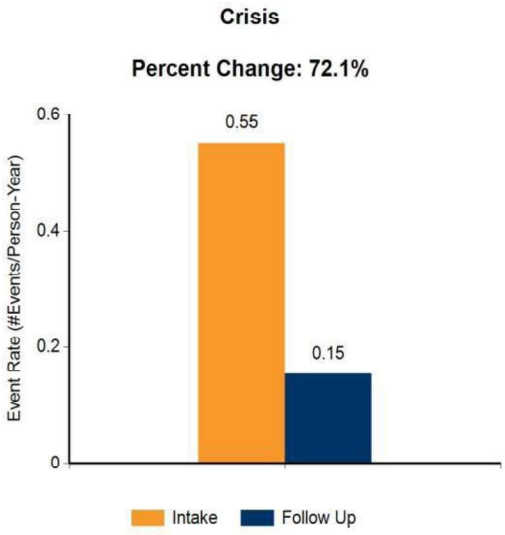



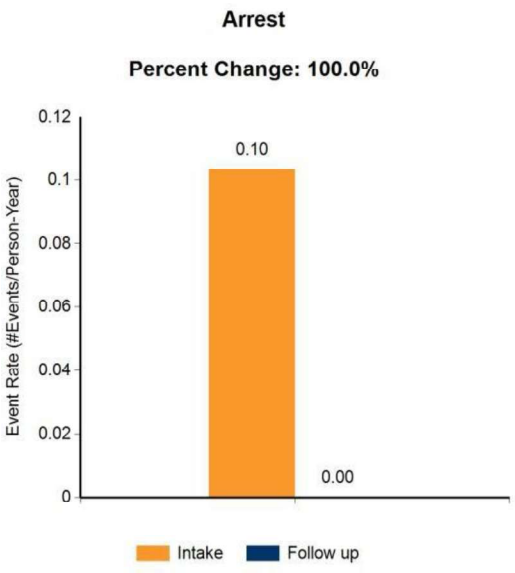

CSS

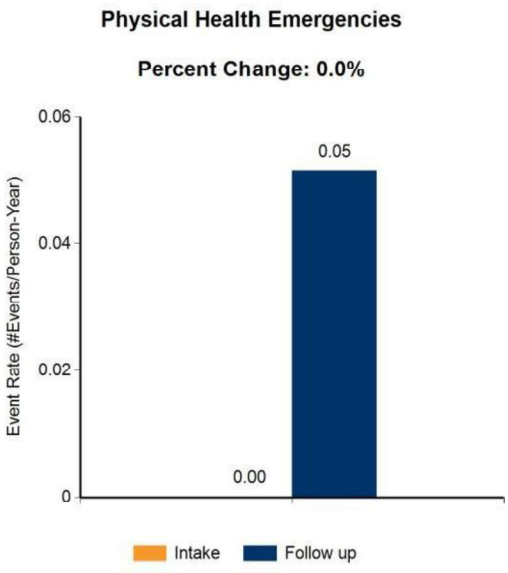
## Outcomes for 33OPFT

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

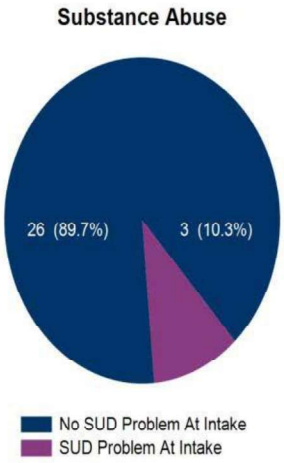


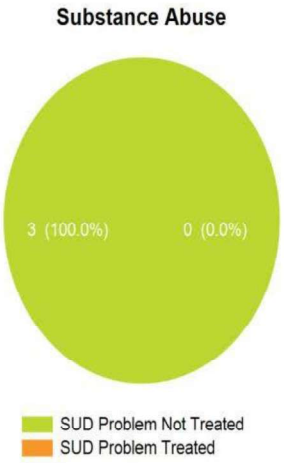



## Outcomes: Substance Use (33OPFT)

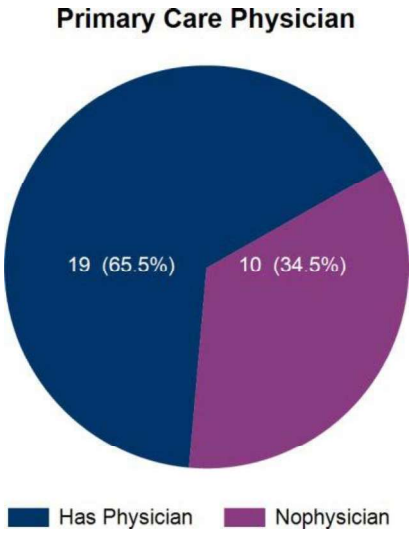



Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (10.3%). The majority of those who had co-occurring MH and SU problems had not been receiving SU treatment services at intake.

Follow-up: Based on quarterly follow-up data, 0.0% (0) of the 3 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 1 consumer not identified at intake was noted to have an SU problem on follow-up, and 0.0% of them were reported to be in SU services on follow-up.

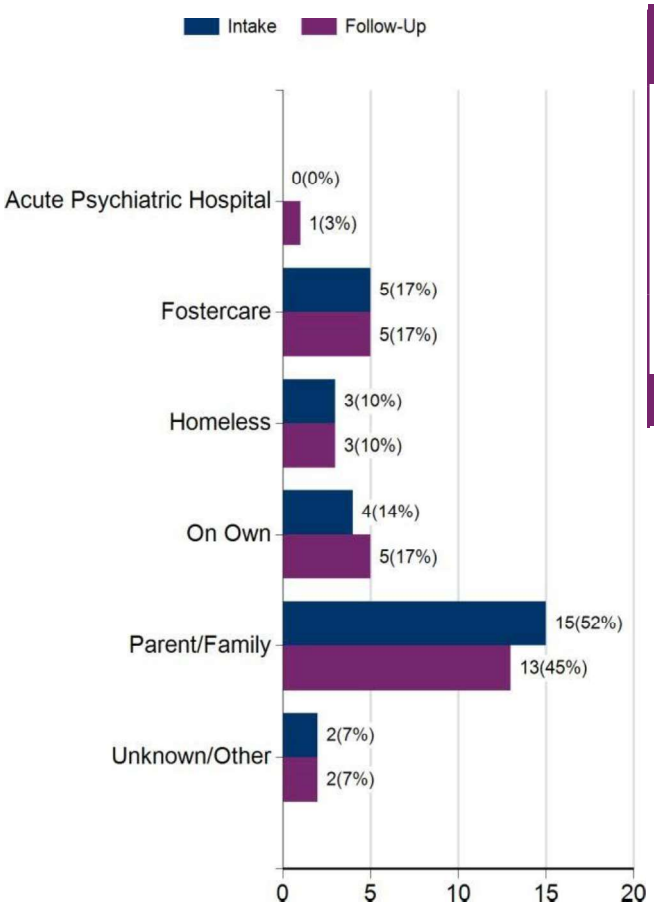
## Outcomes: Primary Care Physician (33OPFT)




Intake: Most consumers (34.5%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 10 consumers that did not have a PCP at intake, 3 (30.0%) obtained a PCP while in the program.

## Outcomes: Residential & Discontinuance (33OPFT)




| Discontinuation Reason | Count | % |
|---|---|---|
| Met goals | 2 | 20% |
| Partner cannot be located | 4 | 40% |
| Partner left program | 1 | 10% |
| Target criteria not met | 3 | 30% |
| **Total** | **10** | **100%** |

## Length of FSP Partnership for: 33OPFT

| TAY Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| >= 1 Year and < 2 Years | 5 | 1 | 6 | 20.69% |
| >= 2 Years and <3 Years | 1 | 0 | 1 | 3.45% |
| >= 90 days and < 1 Year | 9 | 3 | 12 | 41.38% |
| Under 90 days | 3 | 7 | 10 | 34.48% |
| **Total Consumer Enrollments** | **18** | **11** | **29** | |

## Service Detail: 33OPFT

| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 2 (15%) | 4 (31%) | 3 (21%) | 3 (25%) | 4 (27%) | 2 (29%) | 2 (18%) | 3 (33%) | 1 (17%) | 4 (40%) | 3 (23%) | 2 (18%) |
| 2-3 | 7 (54%) | 2 (15%) | 4 (29%) | 1 (8%) | 6 (40%) | 3 (43%) | 6 (55%) | 3 (33%) | 1 (17%) | 3 (30%) | 3 (23%) | 2 (18%) |
| 4-7 | 3 (23%) | 6 (46%) | 5 (36%) | 4 (33%) | 2 (13%) | 1 (14%) | 2 (18%) | 2 (22%) | 3 (50%) | 3 (30%) | 3 (23%) | 3 (27%) |
| 8-13 | 0 (0%) | 1 (8%) | 2 (14%) | 4 (33%) | 1 (7%) | 1 (14%) | 0 (0%) | 0 (0%) | 1 (17%) | 0 (0%) | 1 (8%) | 2 (18%) |
| 14-19 | 1 (8%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (7%) | 0 (0%) | 1 (9%) | 1 (11%) | 0 (0%) | 0 (0%) | 2 (15%) | 2 (18%) |
| 20-25 | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (7%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| 26-31 | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (8%) | 0 (0%) |
| Monthly Total | 13 | 13 | 14 | 12 | 15 | 7 | 11 | 9 | 6 | 10 | 13 | 11 |

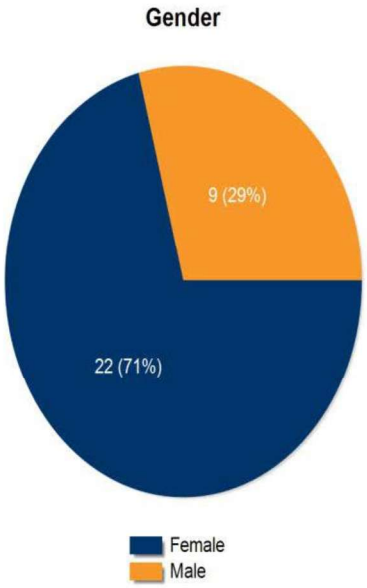
| Type of Service | % of TAY | # of Svcs | Avg. # Svcs |
|---|---|---|---|

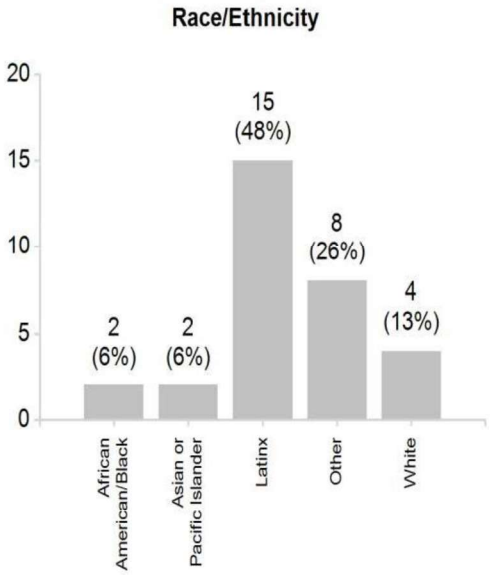
**FSP TAY demographics and Outcomes for:**
**33PBFT Served by this reporting unit: 31**
**Enrollment: 31**

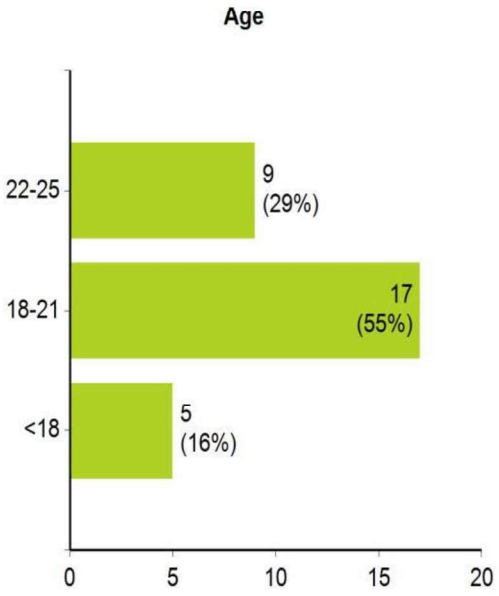
## Demographics

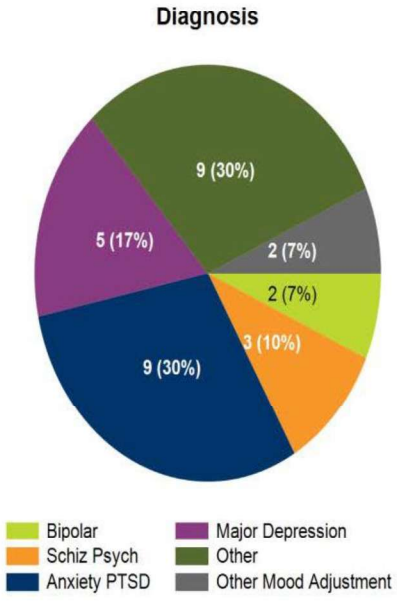
29% of consumers were male and 71% were female.
13% of consumers were White, 48% were Latinx, and 6% were Black/African American.
55% of consumers were 18 to 21 years old.

## Outcomes for 33PBF



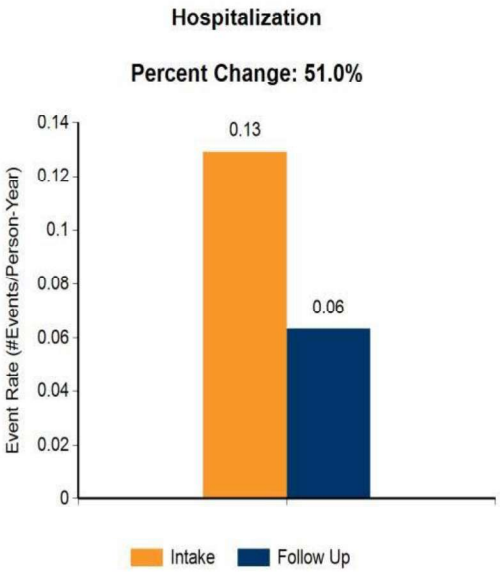



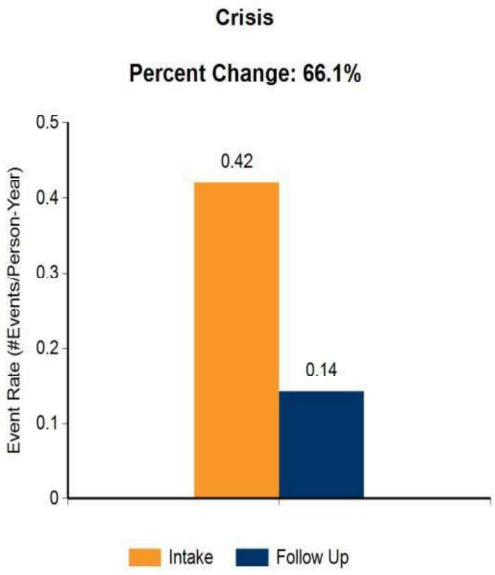



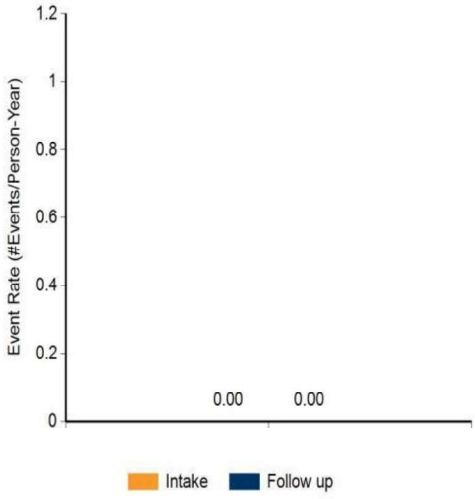



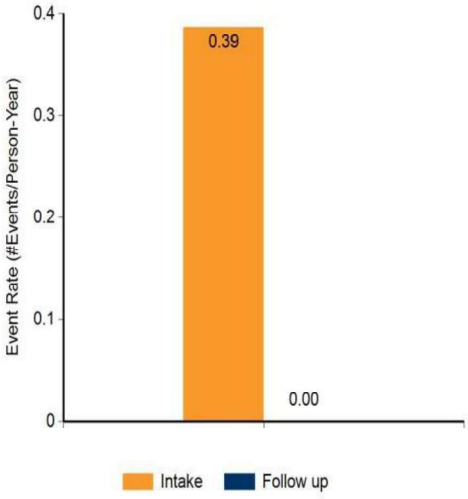
# Outcomes for 33PBFT

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

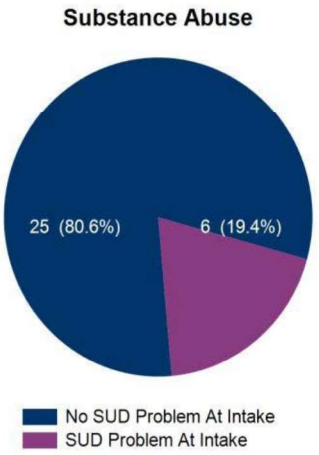


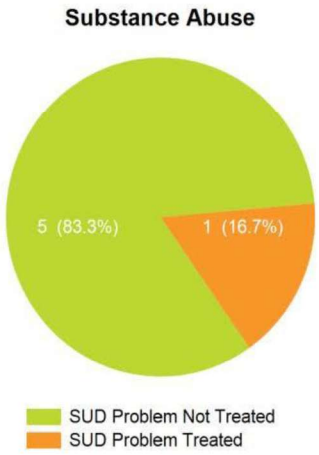



## Outcomes: Substance Use (33PBFT)

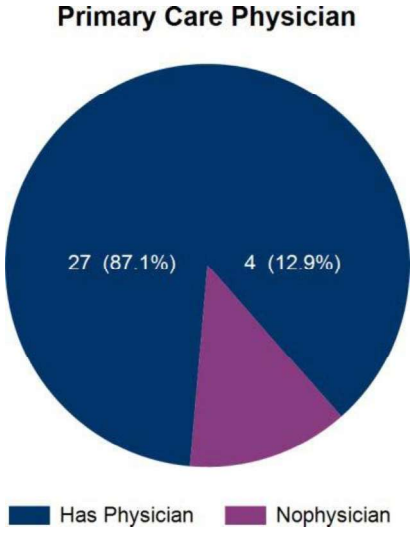



Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (19.4%). The majority of those who had co-occurring MH and SU problems had not been receiving SU treatment services at intake.

Follow-up: Based on quarterly follow-up data, 0.0% (0) of the five people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional one consumer not identified at intake was noted to have an SU problem on follow-up, and 0.0% of them were reported to be in SU services on follow-up.

## Outcomes: Primary Care Physician (33PBFT)

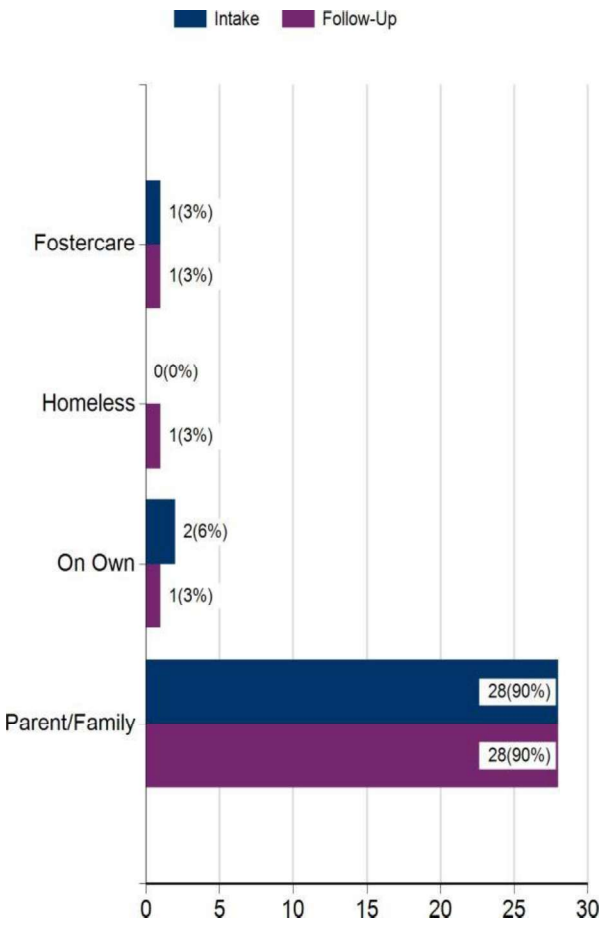



Intake: Most consumers (12.9%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 4 consumers that did not have a PCP at intake, 2 (50.0%) obtained a PCP while in the program.

## Outcomes: Residential & Discontinuance (33PBFT)

| Discontinuation Reason | Count | % |
|---|---|---|
| Total | 0 | 100% |




## Length of FSP Partnership for: 33PBFT

| TAY Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| >= 1 Year and < 2 Years | 2 | 6 | 8 | 25.81% |
| >= 2 Years and <3 Years | 10 | 3 | 13 | 41.94% |
| >= 3 Years and < 4 Years | 1 | 4 | 5 | 16.13% |
| >= 90 days and < 1 Year | 4 | 1 | 5 | 16.13% |
| **Total Consumer Enrollments** | **17** | **14** | **31** | |

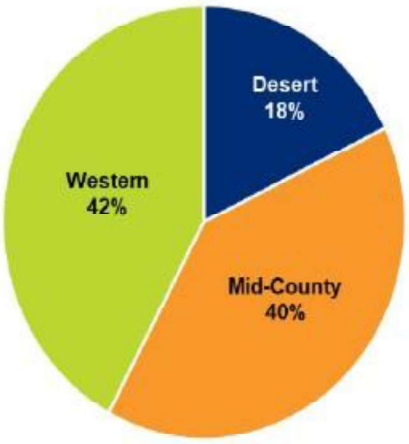
## Service Detail:33PBFT

| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 5 (21%) | 7 (26%) | 2 (10%) | 0 (0%) | 1 (5%) | 0 (0%) | 2 (11%) | 5 (31%) | 1 (7%) | 1 (7%) | 3 (21%) | 1 (7%) |
| 2-3 | 12 (50%) | 8 (30%) | 7 (35%) | 5 (24%) | 11 (50%) | 10 (48%) | 2 (11%) | 3 (19%) | 3 (20%) | 3 (21%) | 2 (14%) | 8 (53%) |
| 4-7 | 7 (29%) | 8 (30%) | 6 (30%) | 6 (29%) | 6 (27%) | 6 (29%) | 9 (50%) | 5 (31%) | 3 (20%) | 8 (57%) | 5 (36%) | 3 (20%) |
| 8-13 | 0 (0%) | 4 (15%) | 4 (20%) | 7 (33%) | 4 (18%) | 3 (14%) | 2 (11%) | 1 (6%) | 7 (47%) | 1 (7%) | 4 (29%) | 3 (20%) |
| 14-19 | 0 (0%) | 0 (0%) | 1 (5%) | 3 (14%) | 0 (0%) | 1 (5%) | 3 (17%) | 1 (6%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| 20-25 | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (5%) | 0 (0%) | 1 (6%) | 1 (7%) | 1 (7%) | 0 (0%) | 0 (0%) |
| Monthly Total | 24 | 27 | 20 | 21 | 22 | 21 | 18 | 16 | 15 | 14 | 14 | 15 |

| Type of Service | % of TAY | # of Svcs | Avg. # Svcs |
|---|---|---|---|

## *TAY FSP*

### TAY FSP




Youth served by TAY FSP was mostly provided by the Western region with 42% (292) of the clients served for the FY 23/24. Followed by the Mid-County 40% (277 ) and Desert with 18% (124).For a total of 693 clients in the FY 23/24.

The table summarizes the clients served by RU and region

| RUs | Desert | Mid-County | Western | Total |
|---|---|---|---|---|
| 33G2FT | | | 261 | 261 |
| 33H6FT | | 85 | | 85 |
| 33HWFT | 95 | | | 95 |
| 33O2FT | | 192 | | 192 |
| 33OPFT | 29 | | | 29 |
| 33PBFT | | | 31 | 31 |
| **Grand Total** | **124** | **277** | **292** | **693** |

## *Western Region: Journey TAY FSP*

The Journey TAY Program outreaches to youth transitioning from adolescent services to adulthood ages 16 – 25. The program office is located in Riverside, California. Areas served include Norco, Corona, Riverside, Moreno Valley, East Valley, Jurupa Valley, Rubidoux, and adjacent unincorporated areas. Although staffing was challenging for fiscal years 22-23 and 23-24, Journey TAY FSP became fully staffed effective September 2024. The team is comprised of

(1) Behavioral Health Service Supervisor
(2) Office Assistants
(3) Behavioral Health Specialists
(1) Licensed Vocational Nurse
(1) Community Services Assistant
(2) Mental Health Peer Specialists
(3) Clinical Therapists
(.5) Psychiatrist.

**3-Year Plan Goal Progress:**

• Integrate a substance use counselor into the treatment team to facilitate coordinated care/treatment since half of consumers have substance issues.

- A Substance Use Counselor position was not added to Journey TAY FSP, and this goal was discontinued. The program has been utilizing SU CARES and/or the Substance Use program to provide substance services for Journey TAY consumers who are interested, willing, and able to participate. Additionally, Journey TAY FSP had two staff, one Clinical Therapist and one Family Advocate Peer, trained in Co-Occurring Disorders Treatment in the summer of 2024. The plan is to have these staff develop and facilitate a Co-Occurring consumer group during the summer of fiscal year 24/25.

• Increase partnership with the Family Advocate program to increase support and incorporate family advocate services into the program:

- Journey TAY FSP made referrals, as applicable, to the Family Advocate program until it can hire a Family Advocate for the program.

• Obtain a Family Advocate position, hire and fill the position, and integrate Family Advocate into the treatment team to provide education and support to family members of consumers served.

- A Family Advocate Peer was hired on November 2, 2023. The Family Advocate has been involved in meetings with family members and consumers, the monthly Transition Age Youth (TAY) and Family Focused Housing Collaborative, and the monthly Western Region TAY Collaborative. The Family Advocate attends and translates for families during doctor appointments, helps consumers and families access records through My Health Pointe, and responds to crisis issues in collaboration with the treatment team. The Family Advocate meets with family

members and consumers to assist them in engaging in mental health services, supports family members in attending family mental health presentations, and receives family advocate mental health support groups.

Journey TAY FSP Consumers Served 261 youth FY 23/24. The Journey TAY program had a 25% decrease in hospitalizations in FY 23/24 and a 78% decrease in arrests in FY 23/24. Crisis emergency room use decreased by 7.2%.

## *Mid-County Region TAY FSP*

**- Victor Community Support Services TAY FSP**

The Victor Community Support Services (VCSS) Transition Age Youth Full-Service Partnership (TAY FSP), located in Perris, offers primarily community and home-based services throughout the region. These services include intensive case management and 24/7 phone support. While some individual services, groups, and medication support are available at the program site, the focus is on reaching youth in their own environments. The program serves young adults aged 16-25 who have long-standing mental health challenges and are at risk of ongoing acute hospitalization, homelessness, or incarceration. A multi-disciplinary team provides comprehensive support and services, encompassing mental health services like individual therapy, medication support, behavioral support, group therapy, and skill building. The team also offers vocational support, housing assistance, peer support services, and family support. Substance abuse referrals and linkages, along with recovery supports, are also integral components of the program.

**Program Goals:**

1) **Treatment Goal Achievement**

- Target: 70%
- Current Performance: 63%

**2) Increase Utilization of ICC, IHBS, and CFTMs**

- Target: 50%
- Current Performance:
    - ICC Services- 42%
    - IHBS Services- 21%
    - CFTMs Services- 22%

**3) Other Notable Data:**

January - December 2024

- Clients Served: 85 Clients

**DEMOGRAPHICS**

- 44% Male
- 55% Female
- 1% Other
- 10% African American/Black
- 17% Caucasian

- 50% Hispanic/Latinx
- 46% of consumers between 16-19 years old
- 11 clients served with eating disorder diagnosis

**3-Year Plan Goals:**

**1- Models of Care Implementation:**

Implement a robust Models of Care framework to improve service delivery, ensure consistency, utilize best practices, and ultimately enhance consumer outcomes. Our Models of Care framework provides a roadmap for effective and efficient service delivery, prioritizing service excellence by addressing the specific needs of the populations we serve. A key component is the use of standardized assessment tools to track client progress and identify areas requiring additional support.

We leverage the following assessments:

- Child and Adolescent Needs and Strengths (CANS): Assesses the mental health needs of children and adolescents.
- Client Assessment of Reintegration Scales (CAIR): Assesses the functional abilities of consumers with mental illness.

CAIR scores play a critical role in our Models of Care, enabling us to:

- Stratify consumers: Match consumers to the most appropriate model of care/program.
- Determine service frequency: Tailor service intensity to individual needs.
- Monitor treatment progress and length of service (LOS): Track client progress over time.
- Evaluate client outcomes: Measure the effectiveness of interventions.

**2- Improving Outcome Data through Training:**

We are committed to improving outcome data through ongoing staff training in evidence-based practices (EBPs). Over the past year, we have made significant progress in this area, providing training in:

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Dialectical Behavior Therapy (DBT)
- Family-Based Therapy (FBT)
- Family Seeing (Family Finding Model)
- Transition to Independence Process Model (TIP)

This investment in staff training ensures the delivery of high-quality, evidence-based care and contributes to improved client outcomes.

- **TAY Expansion**

We submitted a comprehensive response to a Request for Proposal (RFP) aimed at significantly expanding our Transitional Age Youth (TAY) program. This expansion is crucial, as it would enable us to provide vital services to 120 unduplicated young adults in our community who are currently in need of support. These individuals, facing significant challenges as they transition to adulthood, would gain access to housing assistance, job

training, mental health support; through our expanded program, empowering them to achieve self-sufficiency and a brighter future

## *Desert Region TAY FSP*

**Oasis TAY FSP**

The Oasis TAY FSP is in Indio and provides an array of services that include a combination of field-based services as well as on-site services to consumers ages 16 – 25. Oasis serves the Desert Region except for Blythe. Oasis provides intensive case management services that offer support and crisis response that is available 24/7. The program serves consumers who have a history of cycling through acute or long-term institutional treatment settings, consumers who are unengaged, and/or homeless (or at risk of homelessness). Services are provided by a multidisciplinary team that embraces the principles of recovery and resilience. The services and supports available through Oasis TAY FSP include but are not limited to psychiatric services, individual and group therapy, skill building, vocational services, housing assistance, substance abuse recovery services, peer support and mentorship, family advocacy, educational support, benefits assistance, and family education. Full staffing includes:

(1) Behavioral Health Service Supervisor
(1) Substance Use Counselor
(4) Clinical Therapists
(1) Mental Health Peer Specialist TAY Peer
(1) .5) Psychiatric Nurse Practitioner
(1) Health Peer Specialist Family Advocate
(1) Date and Records Clerk
(1) Quality Assurance.

**Notable Data:**

- 55% of consumers served were female, 40 % male, and 5 % transgender.
- 63% of consumers served were Hispanic/Latino; 17% Caucasian; 10 % African American/Black; 3% Asian or Pacific Islander; 1% other and 6% unknown.
- Average length of stay is 2.2 years (median 1.5 years).
- Average enrollment date for non-urgent referrals was 6.6 business days.
- Internalizing Disorders: 70% with mood disorders and 47% with anxiety disorders.
- Major Mental Illness: 37% with schizophrenia and other psychoses NOS

**Program Specific Challenges**:

- Environmental impacts affecting behavioral health (77%)
- Overall, close to 90% have more than one primary mental health diagnosis. There is also a high prevalence of substance use disorder, 26% overall, with 40% having risk in this area.
- In addition, 20% have overdose and/or self-harm risks.

**Program Specific Successes:**

- Implemented a comprehensive Dialectical Behavior Therapy program, which includes a beginning skills group, intermediate to advanced group, and individual and family skills sessions.
- Stars Behavioral Health Group was awarded a grant to participate in CBT-P training with Stanford University. One clinician will receive Level III certification in the full formulation training, and one is in the CBT-P skills group. All four therapists have completed Level I training in this program.

**3-Year Plan Progress Goals**

- Maintain an average monthly census of 85-90. Update: We maintained an average monthly census of 66, below our goal. Ongoing goal.

- Increase the number of clinical and mental health services in the clinical and mental health services groups. Update: Increased group services by 100%, with 341 group service entries for fiscal year 2023-2024. For comparison, only 36 group services were entered from July 1, 2023- to December 31, 2023, and 305 were entered from January 1, 2024, to June 30, 2024. Ongoing goal.

- Increase tracking of no-show rate and decrease no-show rate. Update: Increased monitoring of no-show rate; there was a substantial rate of contact between FSP providers, with only 2.3% of no-shows in the past year.

- Begin using and tracking collaborative documentation. Update: We began completing and tracking collaborative documentation in January 2023 and increased CD to 20%.

**Annual Goal Highlights:**

- Hired and retained staff, including maintaining four full-time Mental Health Clinicians (2 being bilingual) for 12 months or longer and 2 Peer Support Specialists hired in September 2024. Ongoing goal.

- Increase the number of ICC/IHBS services provided and continue tracking, which is an ongoing goal.

## Adult Full-Service Partnership (FSP)

**FSP Outreach and Facilitated Care Linkage**

We conduct outreach and engagement to clients in acute psychiatric hospital care settings (Emergency Treatment Services, Inpatient Treatment Services, and the Desert Psychiatric Health Facility) by connecting them to Full-Service Partnership (FSP) services prior to hospital discharge. This starts engagement and wraps care around the client before they leave the hospital.

Outpatient program liaisons work with acute inpatient treatment staff and engage directly with consumers. This initiates the connection to help navigate outpatient care and encourage ongoing outpatient services. This early rapport-building creates a link to an FSP team, facilitates dedicated outreach and follow-up for consumers in pre-contemplative stages of change, and establishes a familiar face for those needing multiple outreach attempts before seeking care.

Psychiatric Liaisons from outpatient full-service partnership programs play a vital role in bridging the gap between psychiatric facilities and directly operated county outpatient mental health services, facilitating seamless transitions and continuity of care for individuals in need of psychiatric support. Intended outcomes include reducing homelessness, incarceration, and psychiatric hospitalization and increasing independent living and overall quality of life.



### *Western Region: Jefferson Wellness Center FSP*

For FY 23-24, Jefferson Wellness Center Full-Service Partnership.
The Adult Full-Service Partnership (FSP) program is designed for adults ages 26-59 who have been diagnosed with a severe mental illness and would benefit from an intensive service program. The foundation of Full-Service Partnerships is doing “whatever it takes” to help individuals on their path to recovery and wellness. The Full-Service Partnership program embraces client-driven services and supports each client in choosing services based on individual needs. Unique to FSP programs are a low staff-to-client ratio, a 24/7 crisis availability, and a team approach that is a partnership between mental health staff and consumers.

The Adult FSP program assists with housing, employment, and education while also offering mental health services and integrated treatment for individuals facing co-occurring mental health and substance abuse disorders. Services are delivered in individuals' homes, communities, and other locations. Peer support groups are available. A key element of Full-Service Partnerships is the commitment to offering culturally and linguistically competent and appropriate services. Members have 24/7 access to dedicated professionals who are committed to helping them achieve important goals such as health, well-being, safety, and stability.

The focal populations include those with a serious mental and persistent mental illness that results in difficulty functioning and experiencing chronic homelessness, justice involvement, psychiatric hospitalization, or long-term care needs due to mental health impairments. community resources. The FSP Program implemented expansion efforts in December 2022 to focus enrollment efforts on psychiatrically hospitalized patients at the Riverside County Regional Medical Center (RCRMC) Inpatient Treatment Facility for the purpose of the post-discharge continuum of care and appropriate FSP level of care linkage.

The program has integrated and assigned a full-time BHS II staff Liaison at ITF to focus on FSP enrollment after psychiatric hospitalization and prevent future hospitalizations and decompensation in the outpatient level of care.

The FSP uses a multidisciplinary team approach when providing services and support. The FSP team comprises a Behavioral Health Services Supervisor, Psychiatrists, Clinical Therapists, Behavioral Health Specialists II, a Licensed Vocational Nurse, Peer Support Specialists, a Family Advocate, and a Community Services Assistant. The team also consistently collaborates with other community-based agencies, including local shelters, Probation, Vacation programs, Urgent care, CRT, and hospitals. Examples of multi-disciplinary services that are provided include, but are not limited to, Outreach and Engagement; Case Management, which includes linkage to community resources, Assessment, Crisis Intervention, Behavioral Health Services (Individual, family, and group therapies), Medication support (Psychiatric Assessment, Medication services and Nursing support), Dialectical Behavior Therapy (DBT), Seeking Safety, Care Coordination Plan development, Peer Support Services, that includes WRAP and Wellness groups, Women's and Men's Support groups, and Adjunctive and Collateral services, such as Probation, family, and other outside supports

### Enhanced Care Management (ECM):

Enhanced Case Management (ECM) was implemented at Jefferson Wellness Clinic FSP on January 1, 2022, and reassigned to the Forensics / Public Guardian / Housing division HHOPE program effective September 19th, 2024.

**Progress Data**

Below are data highlights for Jefferson Wellness Center for the FY 23-24. This data is from The Full-Service Partnership Adult Outcomes Report for fiscal year 2023 - 2024.

### Jefferson Wellness Center FSP:

• The program served and enrolled FSP 366 clients in FY 23/24 at the Jefferson Wellness program.
• More than a third of clients received 8 or more monthly services.
• The services provided were Individual Mental Health Services, Medication Services, and Case Management.
• Arrests were down 97% for Jefferson Wellness Center clients.

• Acute hospitalizations were down 38% for Jefferson Wellness Center clients, and crisis emergency room use decreased by 30%.
• The percentage of clients living independently increased from 14% to 18%.
• Homelessness decreased from 17% to 15%.

**Three-year plan goal:**

• Increase the frequency of services provided to enrolled FSP clients so that 85 percent receive an average of 5-8 or more services a month to improve member outcomes.

• Increase enrollment of psychiatric hospitalized patients at the Riverside County Regional Medical Center (RCRMC) Inpatient Treatment Facility to establish a post-discharge continuum of care and appropriate FSP level of care linkage.

• Decrease acute hospitalizations for Jefferson Wellness Center clients and crisis emergency room utilization.

• Continuous focus on lowering criminal justice involvement, reducing homelessness, and fewer hospitalizations and emergency department visits.
• Increase member linkage to housing, substance use disorder services, ECM services, and primary care resources to address physical health needs and adhere to the Cal Aim no wrong door at the point of entry.

# Adult Outpatient Clinics FSP Tracks

## Western Region: Blaine Street Clinic FSP Expansion

Blaine Street Clinic is an integrated adult outpatient program that provides access to a wide range of recovery and rehabilitation services and supports to adults ages 18 – 59 diagnosed with a severe and persistent mental illness who are living in the Western Region of Riverside County. The clinic offers comprehensive mental and psychiatric treatment services, integrated behavioral health outpatient services, and coordination of medical treatment. Treatment modality includes crisis intervention, psychiatric assessments, recovery management, medication services, case management, and dual-diagnosis treatment. Services are provided by a multidisciplinary staff of mental health professionals: Psychiatrists, Nurses, Clinical Therapists, Clinical Student Interns, Behavioral Health Specialists, Peer Support Specialists, Family Support Specialists, and Community Services Assistants.

Providers collaborate with consumers to develop individualized plans to address each person's goals for recovery. The collaborative care approach encompasses peer-to-peer support, individual and group therapy, recovery-oriented support groups, and specialized group treatment focusing on consumers recovering from both behavioral health and substance use challenges. Additionally, the provision of direct services and collaborative care include but are not limited to building support networks through the inclusion of family and supportive partners in the planning and recovery process, case management to facilitate linkage to community resources, programs, and other agencies as needed, peer and family support services, medical care and health education.

**Program:**
The FSP target population is adults ages 26-59 who have been diagnosed with a severe mental illness and would benefit from an intensive outpatient service program. The focal population meets one or more of the following criteria: homeless, justice-involved, and high utilizers of psychiatric hospitals or long-term care facilities due to mental health impairments. In December 2022, the FSP program implemented collaborative care processes with the Riverside County Regional Medical Center (RCRMC) Inpatient Treatment Facility (ITF) for the purpose of linking psychiatrically hospitalized patients to FSP level of care post-discharge. Embedded in Full-Service Partnerships is a commitment to deliver services in culturally and linguistically competent and appropriate ways. In FY 23-24, the Blaine FSP served, and FSP enrolled 191 consumers. Two-thirds of the Blaine FSP served had 4 or more services each month.

- Psychiatric hospitalizations decreased 48%, and crisis usage decreased 22%. Hospitalizations for Physical Health also decreased by 30%
- Arrests decreased 38%

**Program Goals:**

• Increase FSP enrollment to reach capacity and maximize service delivery. This includes increasing the high utilization of enrollment through collaboration with Riverside County Regional Medical Center (RCRMC) Inpatient Treatment Facility (ITF).

• Increase the average number of services provided to enrolled FSP clients so that 80% receive an average of 5-8 or more services a month to improve member outcomes.

• Reduce severe mental health symptoms, homelessness, incarceration, and psychiatric hospitalization.

• Continuous focus on lowering criminal justice involvement, reducing homelessness, and fewer hospitalizations and emergency department visits.

• Increase field-based treatment modality individual and group treatment.

• Increase member linkage to housing, substance use disorder services, ECM services, and primary care resources to address physical health needs and adhere to the Cal Aim no wrong door at the point of entry.

### *Desert Outpatient Adult FSP*

Other Desert Region Outpatient programs are developing FSP service tracks in outpatient clinics within the Desert Region. These FSP tracks operate in Children's, Transitional Age Youth, Adult, and Mature Adult programs. The Adult Outpatient Clinic program's current FSP consumer census is as follows:

Indio Outpatient Clinic: 145
Banning Outpatient Clinic: 45
Blythe Outpatient Clinic: 14

These clinics have transitioned appropriate current and future consumers into FSP programming within their services. The process of transitioning consumers who meet the criteria for this higher level of need is based on current staffing levels as well as consumer challenges and their ability to benefit from this higher level of care. The Banning Outpatient Clinic has seen success in creating a distinct FSP team inside of the Outpatient clinic. The Indio Outpatient Clinic has also developed distinct FSP service teams due to a significant increase in identified consumers, including the transition of previous Oasis Case Management FSP consumers. The team comprises a Clinical Therapist, a Behavioral Health Specialist, and a Peer Support Specialist. This has resulted in increased field-based services, improved engagement in treatment services to include psychiatry and therapy (group and individual), and increased facilitation of entry into permanent housing. Another contributing factor in the increase of the FSP census in Desert Adult Outpatient programs is the entry of all consumers who enter ITF and PHF units while the consumer is still in the unit. The outpatient staff works collaboratively with liaisons on ITF and PHF to open consumers into services and complete the PAF for

enrollment into FSP services. Upon discharge from the psychiatry facility, the FSP team works to engage the consumer in services.

Evidence-based Practices utilized in Desert Adult Outpatient clinics include Dialectical Behavior Therapy, CORE, and Seeking Safety. Delivering these EBPs in conjunction with providing these more intensive FSP-level services is intended to decrease psychiatric hospitalization and incarceration, increase support to assist consumers with obtaining and maintaining housing, and assist consumers with developing life skills to create sustainable self-sufficiency.

The consumers who have transitioned to this level of care have verbalized that this level of service has benefited their wellness and recovery, including decreasing barriers to accessing care due to staff engaging in field visits and linkage with community resources such as housing. The staff who have been able to provide this level of care have verbalized their enjoyment in working more intensively with this consumer population and acknowledge the challenges when consumers experience relapses in their recovery. The newly defined FSP team has experienced some challenges as the FSP caseload quickly increased due to ITF entries and improved community engagement.



**Desert Adult Outpatient Goals:**

1. Increase the number of unique FSP consumers served in outpatient clinics.
2. Increase in the number of field-based services provided.
3. Increase engagement in psychiatry and other therapeutic services as evidenced by an increase in a number of services provided.

### Desert: Oasis Case Management Team

The success of the Windy Springs program has fostered an examination of programs that could benefit from enhancement to the FSP level of care. One of these programs is the longstanding program of Oasis Case Management.

A central goal of this program is early engagement in intensive case management services to enhance symptom reduction and assist consumers with meeting longer-term goals. This program provides intensive case management and outpatient care.

The Oasis Case Management Team served 427 FSP consumers. We have increased the Oasis Case Management services to include in-reach services to hospitalized consumers. This program aims to improve follow-up care in outpatient FSP or clinic outpatient care. Outpatient care is provided onsite to 50 board and care consumers and includes intensive case management and group and individual therapy services. Evidence-based Practices utilized include Dialectical Behavioral Therapy.

**Goals for Oasis Case Management Program:**

- Decrease in psychiatric hospitalizations.
- 2. Maintain housing in the least restrictive setting, including entering community housing vs. board and care.

- 3. Improve linkage and follow-up with both FSP and non-FSP outpatient services, as evidenced by consumers entering outpatient RU and transitioning out of the Oasis Case Management program when appropriate.
    - 44% had a schizophrenia psychosis diagnosis
    - 60% of consumers were male and 40% were female.
    - 27% of consumers were White, 44% were Latinx and 9% were Black/African American.
    - 20% of consumers were 40 to 49 years old
    - Acute hospitalizations were down 19.9%, and crisis emergency room use decreased by 15%.
    - Arrests were down by 100%
    - Based on quarterly follow-up data, 1.8% (4) of the 220 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional six consumers not identified at intake were noted to have an SU problem on follow-up, and 2.0% of them were reported to be in SU services on follow-up.
    - Most adults (76.3%) did not have a primary care physician (PCP) at intake. At follow-up, of the 326 consumers that did not have a PCP at intake, 1 (6%) obtained a PCP while in the program
    -

**Desert Region: Windy Springs Wellness Center FSP**

Currently located at Windy Springs, 19531 McLane Street, Suite B, Palm Springs, CA 92262. The Windy Springs Program, or Desert Adult Full-Service Partnership (DAFSP), is an intensive psychiatric case management program for Desert Region Riverside County residents with severe persistent mental illness, a history of chronic homelessness, and multiple psychiatric hospitalizations. Full Services Partnership (FSP) programs were designed in the Mental Health Service Act to serve consumers in chronic need of stabilization. The FSP also addresses the needs of consumers who have not responded to traditional outpatient behavioral health programs. These services remain a priority for Riverside University Health System – Behavioral Health. Services include: psychiatric care, medication management, intensive case management, crisis services, 24/7 after-hours hotline, housing assistance, Dialectical Behavioral Therapy (individual and group), substance abuse treatment and relapse prevention, peer support care, and family advocacy. Intensive treatment and after-hours care are focused on symptom reduction, coping skill identification, wellness support, relapse prevention, and reduction of emergency services intervention. The goal of the FSP is to assist the consumer in learning new ways to manage behavioral health crises, maintain current residency, stop jail recidivism, stop psychiatric hospitalization, as well as sustain the current level of recovery. Another key component of care with this population is comorbid medical issues. The Windy Springs FSP treats over 250 consumers a month. Approximately 92 of these consumers reside at Roy's Augmented Board and Care, which is in the suite next to the Windy Springs FSP. Additionally, this program supports the PATH, a Housing First program that has a capacity of 26 residents. The Windy Springs staff collaborate with the Residential Care staff of both programs to support these consumers in pursuing their recovery journey.

Assisting consumers with complex issues and multiple behavioral health and substance abuse challenges involves engaging consumers, addressing consumer setbacks, re-engaging in care, and rediscovering wellness goals. This process is often not linear. Thus, staff are empowered to role model self-care and allow for mercy while holding the hope that consumers will make strong wellness choices. Staff work hard to identify consumer needs and meet them where they are at in their recovery journey. A key aspect of care in these settings is for direct care providers to hold the hope of recovery and show compassion while supporting consumers in acceptance and change.

The extreme weather conditions of the Desert Region climate create significant risk for this population, especially during the summer months. For FSP consumers who are homeless or at risk for homelessness, symptom management and the ability to be successful in supportive housing programs or board and care programs is an essential element in maintaining wellness and safety in their daily lives. These housing programs rely on the assistance of FSP staff to successfully support their residents. This FSP support occurs 24 hours a day, 7 days a week. This care can be rewarding when consumers can make sustained lifestyle changes, but also can be challenging when consumers experience a return of symptoms.

**Goals for Windy Springs Wellness Center:**

1. Decrease in psychiatric hospitalizations.
2. Increase in housing stability and maintenance as evidenced by fewer consumers returning to unhoused status
3. Decrease in the number of conservatees returning to IMD level of care.
4. Decrease in incarceration as evidenced by data gathered.
5. Increase in accessing SUD services.

The data from these programs continues to show improvement in several key life indicators, including a decrease in hospitalizations, a decrease in interactions with law enforcement, an improvement in housing stability, including maintaining housing in the least restrictive environments, a decrease in behavioral health crises, improved follow-through with medical care, and a decrease in the use of non-prescribed medication or recreational drug use.

The Desert Region Windy Springs FSP served 264 consumers in FY 23/24,

- 64% had a schizophrenia psychosis diagnosis.
- Race/Ethnicity data showed 43% of the served were White, 32% were Hispanic/Latinx, and 10% were Black/African American.
- 69% were male, 31% were female, and 52% were age 40 and older.
- The majority of consumers received eight or more services per month.
- Most of the services provided were individual mental health and case management services followed by medication services.
- Arrests were down 100% for Windy Springs consumers.
- Acute hospitalizations were down 57.2% for Windy Springs consumers, and crisis emergency room use decreased by 51%.
- Homelessness decreased from 12% to 6%.

• Residential placement in a supportive care setting increased from 32% to 48%.
• Of the 126 consumers who did not have a PCP at intake, 120 (95.0%) obtained a PCP while in the program.

• 61.3% of the 80 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 55 consumers not identified at intake were noted to have an SU problem on follow-up and 61.0% of them were reported to be in SU services on follow-up.

## *Mid-County Adult FSP*

Full-Service Partnership (FSP) aims to provide client-centered care through intensive case management, therapeutic interventions, and a focus on recovery. FSP clients work with clinic staff to become self-reliant by addressing immediate needs and setting personal goals. Staff members assist with creating action plans to address mental health treatment, living arrangements, social relationships/communication, financial/money management, activities of daily living, educational/vocational, legal issues, substance abuse issues, physical health, and psychiatric medications. Each clinic provides personalized services and supports to create a client path to recovery.

### Mid-County Adult Clinic Tracks

• Mid-County Behavioral Health Adult Clinics and FSP Tracks
• Hemet Behavioral Health Adult Clinic/ FSP Track-284 enrolled and served.
• Lake Elsinore Behavioral Health Adult Clinic / FSP Track-88 enrolled and served.
• Perris Family Room / FSP Track -73 enrolled and served.
• Temecula Behavioral Health Adult Clinic/ FSP Track-55 enrolled and served.
• Mid-County Behavioral Health Adult clinics served 4,588 consumers in their non-FSP tracks and 500 FSP consumers.
• We have four locations for FSP services throughout the Mid-County region, creating multiple access points and convenience for individuals living outside the county's central metropolitan area. By having FSP services at the clinic sites, there has been an increase in FSP client sustainability.
• All FSP consumers have full access to clinic services, which include clinical and medication assessments, medication management, individual therapy, group therapy, psychoeducational groups, care coordination, and case management. The theoretical models include Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, the Family Room Model, Motivational Interviewing, WRAP Around and others.
• Anticipated Changes: Each clinic will work to increase FSP enrollment. As the department has stepped down from mild-to-moderate clients to other care providers, the focus on clients with serious mental illness necessitates more FSP services. Additionally, all clinics will be reaching and engaging the surrounding community to establish community resources.
• Lessons Learned: It has been discovered that FSP services are essential on the road to recovery of the seriously mentally ill and those showing signs of having severe mental health crises/episodes.

• Challenges: Employee retention is the major challenge for the clinics. Due to other companies offering more flexibility and higher pay, keeping staff members who are not vested in the department has been difficult.

Hemet Behavioral Health Adult Clinic / FSP Track Groups

MONDAYS

- Mindfulness/Journal
- Grief Group
- Interpersonal Skills
- RAP
- Trauma/Codependency
- Self-Esteem
- Grupo De Apoyo Familiar

TUESDAYS:

- Mindful Journaling (10-11:30)
- Interpersonal Skills
- The Art of Story Telling
- Life Skills
- Coping Skills
- The Art of Crochet
- Mindfulness journaling (3-4:30)

WEDNESDAYS:

- RAP
- Cafecita Time (Spanish)
- Chair Yoga
- DBT
- Substance Abuse (CORE)
- RAP (Spanish)
- Mommy and Me (Pending)
- Peer Support
- English Family Group

THURSDAYS:

- Kickback Art
- Creative Recovery
- Anxiety/CBT
- Body Keeps the Score
- Spanish Peer Support

Also help on Thursdays at the clinic is:

- Pathways Success
- NAMI

FRIDAYS:

- Chair Yoga
- Creative Recovery
- Coping Skills
- Mindful Horizons
- Women's Group
- Art-E (Bilingual)
- Rhythmic Expressions

**Lake Elsinore Behavioral Health Adult Clinic / FSP Track Groups**

- Alternative Perceptions
- Art
- Family Empowerment
- Family Support (English & Spanish)
- Peer Support (English & Spanish)
- Planning for Success
- Women's Empowerment
- Pokémon Go (TAY)
- Inside Out
- Music
- Socialization
- Clinic Orientation (starting next month)

**Temecula Behavioral Health Adult Clinic / FSP Track Groups**

- Dialectical Behavior Therapy (3 separate groups per week)
- Kick Back Art (once per week)
- Clinic Cinema (Peer-led discussion group viewing a mental health theme movie once per week)
- Vinyl's and Validation (Peer-led discussion group based on music as a recovery tool once per week)

**Perris Family Room / FSP Track Groups**

- CORE I
- Art and Creativity – English and Spanish
- Mastering Anxiety
- Wise Mind (DBT)
- Peer Support - English and Spanish
- Recovery Management
- Family Support – English and Spanish
- Whole Health
- Ecotherapy
- Modern living
- Inside out

**Progress Data:**

Data collection is an ongoing aspect of evaluating the operation and efficiency of each FSP track. Priorities include staff responsiveness to consumers in crisis and stabilizing clients in the community. Staff retention is also critical for the continuity of care and to preserve the consistency of the FSP team. The designated case managers are trained and experienced in entering and tracking information in ImagineNet. Each FSP track has a weekly meeting related to the consultation and monitoring of consumers.

Collected data in ImagineNet will prove valuable at directing future services. Incoming staff continue to be trained and are learning to enter required data. The Behavioral Health Services Supervisors are highly engaged and involved in overseeing FSP operations as it represents a huge component of clinical care.

7/1/2023 to 6/30/2024

| | |
|---|---|
| 3377NA | 2,027 |
| 3377FA | 433 |
| 33MUNA | 838 |
| 33MUFA | 133 |
| 3383NA | 1,148 |
| 3383FA | 132 |
| 33MTNA | 714 |
| 33MTFA | 66 |

**3-Year Plan Goal:**

• Increase FSP client numbers by 20%, each clinic

• Increase community outreach and engagement through participating in community events and collaborating with community groups

- Follow up on goals: Hemet and Perris Mid-County Adult FSP met their goal to increase numbers by 20%. Hemet had an increase of 30%, and Perris had an increase of 31%. Lake Elsinore was also able to meet their goal. They had an increase of 41%.
- Temecula was unable to meet its goal, and it had a decrease of 3% due to staffing challenges. The clinic operates with 2 case managers, and they don't have a Community Services Assistant to provide transportation to needy clients. Current staff are unable to serve more clients as caseloads increase. They could hire a community service assistant and another BHS but towards the end of the year. This should help increase the population served for the next reporting cycle.

• The second goal is to Increase community outreach and engagement through participating in community events and collaborating with community groups; mid-county Adult Clinics were successful with this goal. Below is a list of events that Lake Elsinore and Hemet were able to participate in to increase community outreach and engagement. Temecula joined forces with Pathways, Mature Adults, SAPT, and the peer resource center and hosted a resource fair called A Decade of Difference to celebrate our 10th anniversary at the Temecula site on Aug 14th. They had food, games, raffles, and resources. The staff did a fantastic job. We had about 95 members sign in. It was a very successful event.

**Hemet**

- Longest Night- December 19, 2024

- May is Mental Health Month Mid-County – May 2024
- Recovery Happens: Fairmont Park- October 2024

**Lake Elsinore**

- Quarterly member clinic parties for our members
- May is Mental Health Month- May 2024

**Temecula**

- Resource fair Aug 2024
- May is mental health month- May 2024

Riverside University HEALTH SYSTEM Behavioral Health

MENTAL HEALTH SERVICES ACT (MHSA)

FULL SERVICE PARTNERSHIP PROGRAM

# Full Service Partnership Adult Outcomes Report FY 2023-2024

## Background

The following report is a summary of outcome data for the Adult Full Service Partnership (FSP) programs. FSP program outcomes are focused on evaluating changes in a consumer's status relative to several quality of life domains. Baseline histories are obtained from consumers at enrollment into the FSP program. Follow-up data is collected on a continuous basis for key life events (e.g., hospitalizations) and is assessed periodically for other select life domains. Outcome reporting is based on comparisons between baseline and post enrollment status and provides a measure of program effectiveness.

The following report is based on FSP data collection from consumers enrolled and served in the Adult FSP programs beginning July 1, 2023 and ending June 30, 2024. Baseline data for this report is based on responses from each of these consumer's Partnership Assessment Form, the history of events for the 12 months before a consumer began the FSP program. Follow up data used in this report is based on two sources. Psychiatric Hospital and Crisis emergency room data has been pulled from actual admissions to the hospital or crisis emergency room data. All other follow-up data used in this report was based on Key Event Tracking (KET) and Three Month Quarterly (3M) assessment forms completed on ImagineNet for these consumers during their enrollment in an adult FSP program.

## FSP Program

Overall, the FSP programs provide an intensive level of service with regionally placed Integrated Service Recovery Centers (ISRC) for Adult and TAY consumers, and Specialty Multidisciplinary Aggressive Response Treatment (SMART) for Older Adults, however, the following report document presents statistics and figures from the Adult FSP programs ***only***.

There are FSP programs in each region of the County including the West, Mid-County, and Desert region. Adult FSP programs include County clinic FSP expansions which began in 21/22 Fiscal Year. All of the County outpatient clinics added an FSP track within the clinic. The Mid-county region began this process sooner than the West and Deset regions.
The clinic FSPs are located regionally and serve consumers who are unengaged, frequenting the hospitial or are homeless or at risk of homelessness. The program also targets consumers who have a history of cycling through acute or long term institutional treatment settings. These centers collaborate with community resources and agencies to meet the vocational, educational, social and housing needs of Adult consumers. Services are provided by a multi-disciplinary team that embraces the principles of recovery and resilience. Services and supports available within the ISRC include psychiatric services, vocational specialists, housing specialists, substance abuse counselors, peer support/mentorship, family education, family advocacy, educational support, and benefits specialists.

## Executive Summary

***Adult Enrollment and Demographics*** **—**During the 2023/2024 fiscal year from July 1, 2023 to June 30, 2024, a total of 1871 adults were served across 2069 enrollments which includes re-enrollments and transfers to one or more of the adult FSP programs. The race/ethnicity of enrollees for this fiscal year was 651 (31.5%) Latino/Hispanic, 576 (27.8%) White, and 238 (11.5%) African American/Black. In each program and countywide, the most common diagnoses among adult FSP consumers was schizophrenia or other psychotic disorders 776 (49.7%). Countywide the largest proportion of consumers were between the ages of 40 and 49 (24%) and the majority enrolled were males (58%).

***Adult Discontinuances*** **—**Across all of the adult programs the most frequently reported discontinuance reason was 'Met Goals' (52%).

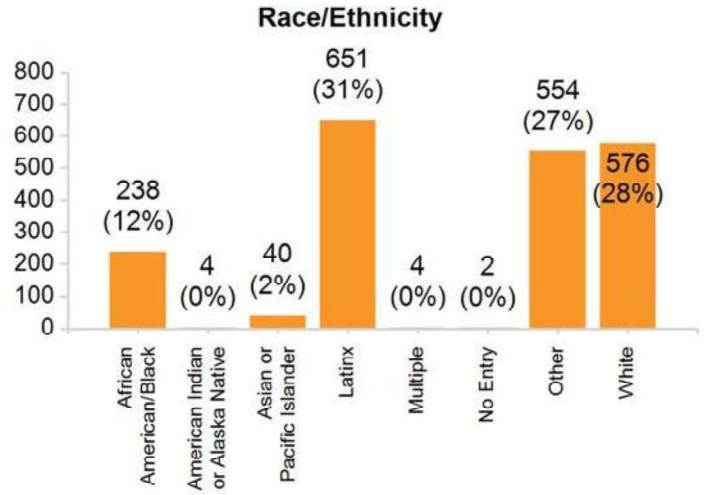
***FSP Services*** **—**In 2023/2024 fiscal year, more than half of the FSP consumers received 4-7 or 8 or more services a month. The highest average hours of services during 2023/2024 fiscal year were for mental health group (31.70 hours), individual mental health services (10.04 hours) and case management (7.14 hours).

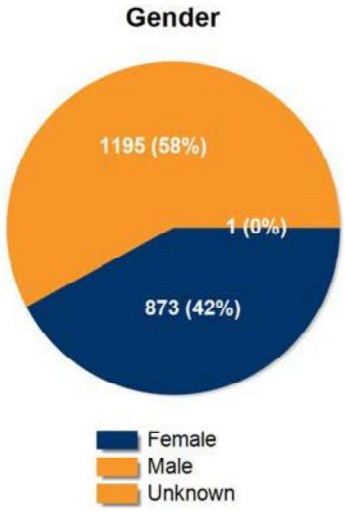
***Adult Outcomes*** **—**Follow-up data for all adult programs combined showed a decrease in hospitalizations (21.73%), arrests (91.62%) , physical health emergency (90.12%) and mental health emergency department visits (35.16%). Programs had 75 to 100 percent decreases in arrests between intake and follow-up. Most programs had decreases in reported hospitalizations. Emergency department visits for mental health services declined by 47% or more for consumers in most programs. Most consumers did not have a primary care physician at the beginning of the program (67.91%), however, nearly three quarters of those (26.11%) obtained one while in the FSP program. Although the majority of those with a co-occurring substance use problem were not receiving treatment at intake, many (17.09%) participated in substance use services while in the FSP. Of the 216 additional consumers that were identified as having an active substance abuse problem during their participation in the adult programs,134(62.04%) were reported to be participating in substance use treatment services while in the FSP program.

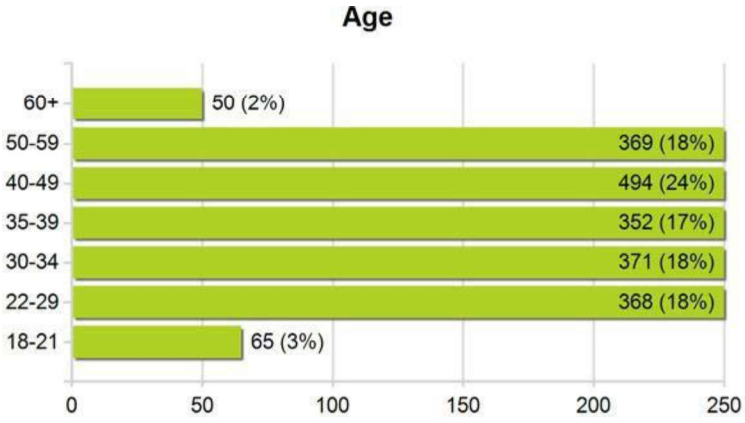
***Residential Status*** **—** Comparisons of intake status and most recent residential status showed that the percentage of consumers reported as homeless or emergency shelter decreased and the proportion living on their own increased.

## Demographics & Diagnosis

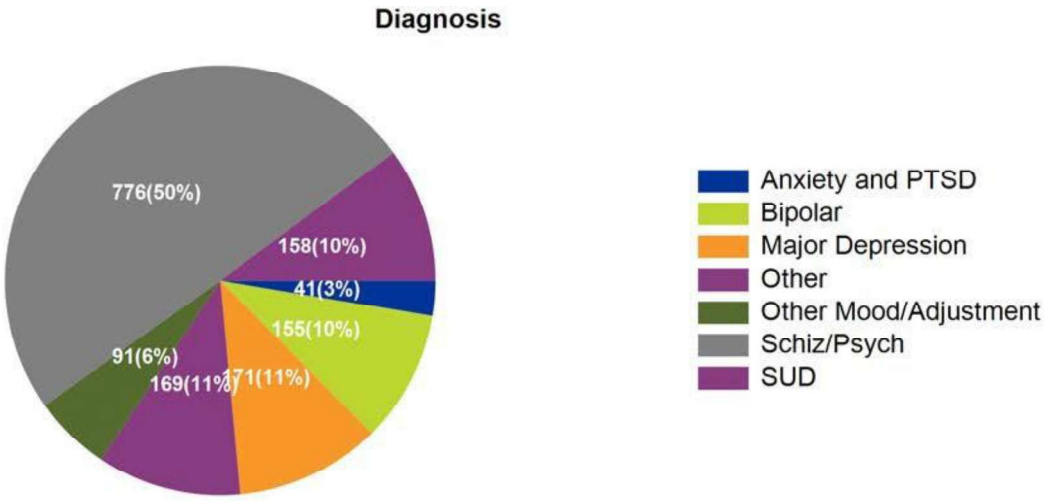
The majority served in the adult FSP program in the 2023/2024 fiscal year were Hispanic/Latinx 31%, which comprise a smaller proportion of those served than their proportion in the Riverside County general population of 51%. The proportion of White, at 28%, was lower than that in the general population of the county at 32%. The proportion of African American/Black participants at 12% was larger than the general population of 6%. Also, more males (58%) have enrolled in the adult FSP program than females (42%).




Most individuals served were between the age of 40-49 (24%) or 50-59 (18%). A large proportion of those served were diagnosed with Schizophrenia/Psychosis disorders (50%), Major depression (11%), or Bipolar disorder (10%).



## Length of FSP Partnership

The length of stay in years for those **2069** enrollments in adult FSP programs during the 2023/2024 fiscal year is shown in the tables below. For reporting time in partnership, the total time a consumer spent in each enrollment is included.

The percentage of adults with an active/open case having time in partnership longer than one year was 39%, while 82% of those with a closed episodes had a LOS in FSP shorter than one year. Of all adult FSP consumers served in FY 2023/2024, over two-thirds have a length of stay less than two years (84%).

FSP re-entry: Of these **2069** adult FSP enrollments, 193 returned to an FSP program after discharging less than a year previously. These consumers are considered to have re-established partnership and 22 of them re-established partnership more than one time over their total time in FSP. The number of consumers that returned to an FSP program after more than a year had passed since discharging from an FSP program was 221.

| Adult Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| >= 1 Year and < 2 Years | 85 | 144 | 229 | 11% |
| >= 2 Years and <3 Years | 75 | 60 | 135 | 7% |
| >= 3 Years and < 4 Years | 17 | 117 | 134 | 6% |
| >= 4 Years and < 5 years | 9 | 29 | 38 | 2% |
| >= 90 days and < 1 Year | 457 | 368 | 825 | 40% |
| >=5 Years and < 6 years | 3 | 11 | 14 | 1% |
| >=6 Years+ | 6 | 14 | 20 | 1% |
| Under 90 days | 447 | 227 | 674 | 33% |
| **Total Consumer Enrollments** | **1099** | **970** | **2069** | |

| | | | |
|---|---|---|---|
| **Average Years in Partnership** | 2.14 | 1.95 | 1.08 |
| **Median Years in Partnership** | 0.29 | 0.74 | 0.45 |
| **Maximum Years in Partnership** | 10.65 | 13.88 | 13.88 |

Length of stay (LOS) for consumers enrolled in each program is described on the following pages. LOS in a program includes only time enrolled in that specific program. Some consumers were enrolled in more than one program during FY 2023/2024 fiscal year or left and returned within the same fiscal year.

*Note: Active cases include those with an open episode in an adult FSP reporting unit as of 6/30/2024. Closed cases include only those that do not have an open episode in an FSP reporting unit as of 6/30/2024. While some consumers leave partnership and later reestablish partnership in the same or different FSP program, time spent inactive is not included in this report.*

## Reason for Discontinuance of FSP: All Adults

Upon termination of partnership a reason for discontinuance is selected. For recorded cases, consumers most often closed because the consumer was Unable to Locate (21%). The next highest proportion of consumers were noted to have Moved out of County/Area (7%). Met Goals accounted for 52% of discontinuance reasons. If a consumer terminated partnership more than once, each instance was recorded in this table.

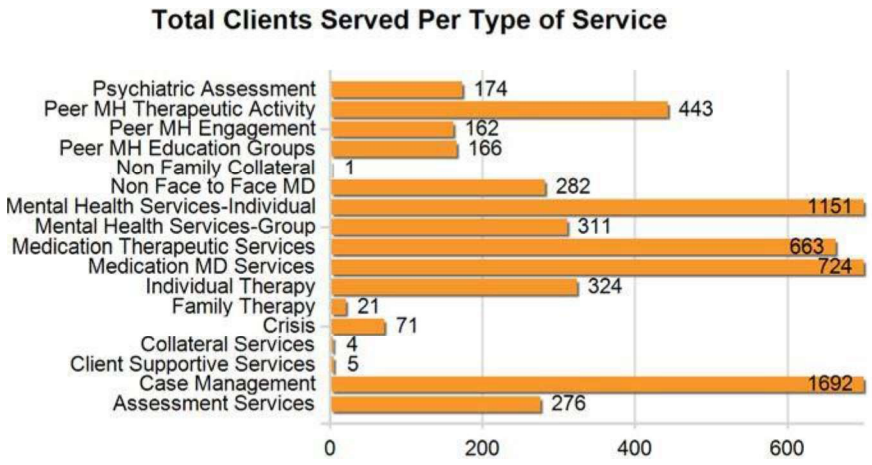
| Discontinuation Reason | Count | % |
|---|---|---|
| **Deceased** | 14 | 1% |
| **Justice system** | 24 | 2% |
| **Met goals** | 505 | 52% |
| **Moved out of county/area** | 66 | 7% |
| **Needs residential care** | 28 | 3% |
| **Other** | 3 | 0% |
| **Partner cannot be located** | 205 | 21% |
| **Partner left program** | 97 | 10% |
| **Target criteria not met** | 26 | 3% |
| **Total** | **968** | **100%** |

## Service Frequency By Month

The table below shows the number of individuals receiving various amounts of services per month, for each of month of the 2023/2024 fiscal year. The majority of consumers received either 4-7, or 8 or more services per month within the fiscal year. On average, more than 30% of adult FSP consumers received 8 or more services per month.

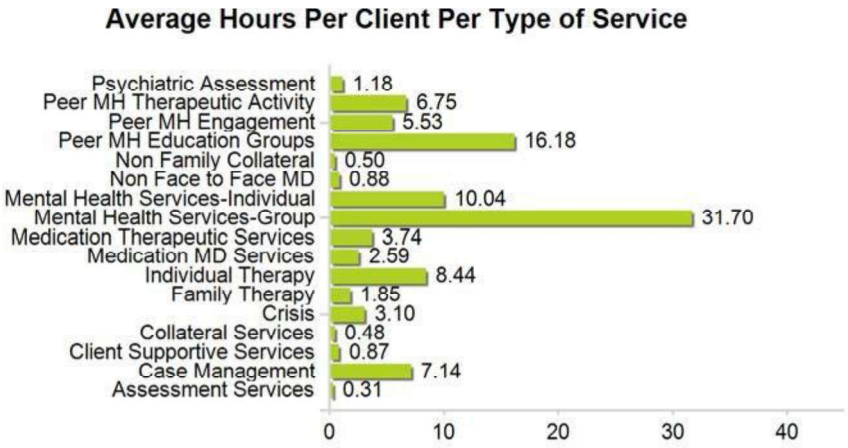
| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 163 (21%) | 144 (18%) | 118 (16%) | 157 (21%) | 154 (21%) | 192 (25%) | 179 (22%) | 129 (18%) | 194 (23%) | 159 (19%) | 133 (17%) | 166 (21%) |
| 2-3 | 170 (22%) | 179 (22%) | 170 (23%) | 168 (22%) | 152 (21%) | 181 (24%) | 183 (23%) | 170 (23%) | 223 (26%) | 174 (21%) | 173 (22%) | 188 (24%) |
| 4-7 | 219 (28%) | 209 (26%) | 235 (32%) | 213 (28%) | 220 (30%) | 202 (26%) | 209 (26%) | 199 (27%) | 206 (24%) | 233 (28%) | 211 (26%) | 217 (28%) |
| 8-13 | 138 (18%) | 167 (21%) | 148 (20%) | 150 (20%) | 146 (20%) | 132 (17%) | 145 (18%) | 145 (20%) | 143 (17%) | 142 (17%) | 159 (20%) | 122 (16%) |
| 14-19 | 49 (6%) | 64 (8%) | 43 (6%) | 41 (5%) | 42 (6%) | 35 (5%) | 56 (7%) | 50 (7%) | 48 (6%) | 78 (9%) | 58 (7%) | 52 (7%) |
| 20-25 | 29 (4%) | 22 (3%) | 13 (2%) | 22 (3%) | 14 (2%) | 12 (2%) | 19 (2%) | 18 (2%) | 27 (3%) | 29 (3%) | 36 (4%) | 20 (3%) |
| 26-31 | 3 (0%) | 11 (1%) | 10 (1%) | 6 (1%) | 6 (1%) | 3 (0%) | 11 (1%) | 8 (1%) | 7 (1%) | 8 (1%) | 16 (2%) | 10 (1%) |
| 32+ | 8 (1%) | 11 (1%) | 7 (1%) | 6 (1%) | 2 (0%) | 6 (1%) | 5 (1%) | 5 (1%) | 6 (1%) | 13 (2%) | 16 (2%) | 8 (1%) |
| Monthly Total | 779 | 807 | 744 | 763 | 736 | 763 | 807 | 724 | 854 | 836 | 802 | 783 |

## Service Detail




During the 2023/2024 Fiscal Year, more clients received Case Management and Mental Health Individual rehabilitation services, followed by Medication services.

The average number of hours consumers received of each type of service while in adult FSP programs during the 2023/2024 fiscal year was calculated. As shown to the right, the average number of hours per consumer was highest in MH Group Services (31.70 hours).

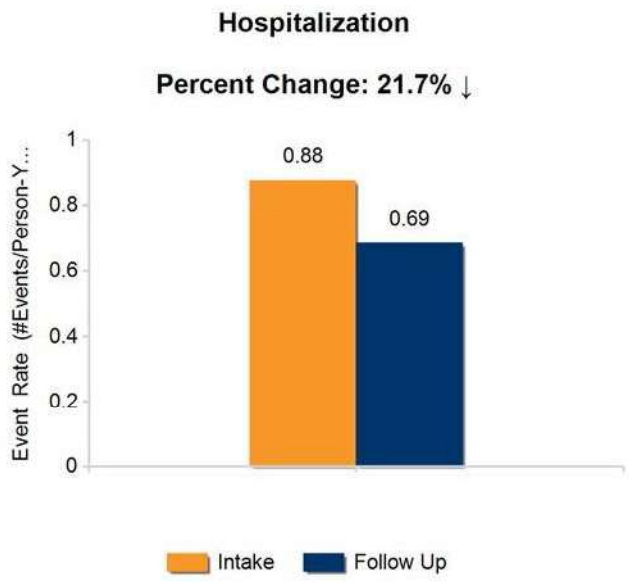



| Type of Service | # of Adult | % of Adult | # of Svcs | Avg. # Svcs |
|---|---|---|---|---|
| Assessment Services | 276 | 13% | 322 | 1.17 |
| Case Management | 1692 | 82% | 17,541 | 10.37 |
| Client Supportive Services | 5 | 0% | 7 | 1.40 |
| Collateral Services | 4 | 0% | 5 | 1.25 |
| Crisis | 71 | 3% | 128 | 1.80 |
| Family Therapy | 21 | 1% | 52 | 2.48 |
| Individual Therapy | 324 | 16% | 3,464 | 10.69 |
| Medication MD Services | 724 | 35% | 2,905 | 4.01 |
| Medication Therapeutic Services | 663 | 32% | 5,306 | 8.00 |
| Mental Health Services-Group | 311 | 15% | 6,529 | 20.99 |
| Mental Health Services-Individual | 1151 | 56% | 16,116 | 14.00 |
| Non Face to Face MD | 282 | 14% | 620 | 2.20 |
| Non Family Collateral | 1 | 0% | 1 | 1.00 |
| Peer MH Education Groups | 166 | 8% | 1,638 | 9.87 |
| Peer MH Engagement | 162 | 8% | 889 | 5.49 |
| Peer MH Therapeutic Activity | 443 | 21% | 3,626 | 8.19 |
| Psychiatric Assessment | 174 | 8% | 179 | 1.03 |

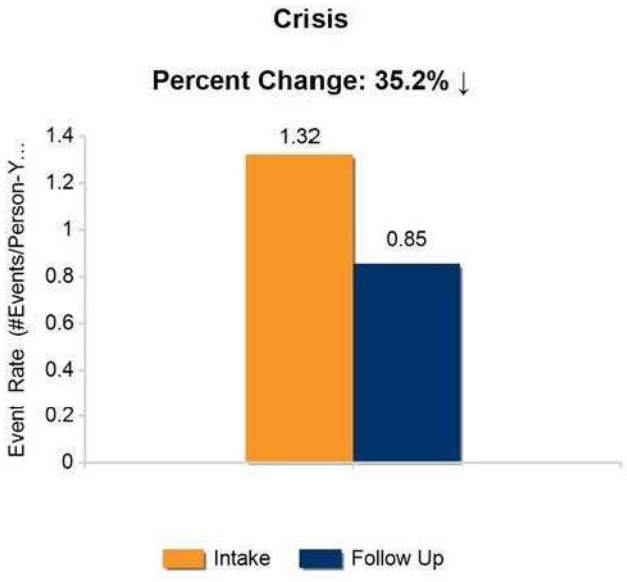
## Outcomes

Primary outcomes of interest for FSP include arrests, physical and mental health emergency room visits, incidences of acute hospitalizations and long-term care. The number of events in the 12 months prior to FSP enrollment are compared with the rate of 'number of events per person-year' in the program (i.e., follow-up). At follow-up, the number of outcome events occurring while enrolled were summed and divided by the number of years all individuals had been in the program. Actual counts for each outcome overall and by program can be found after page 11.

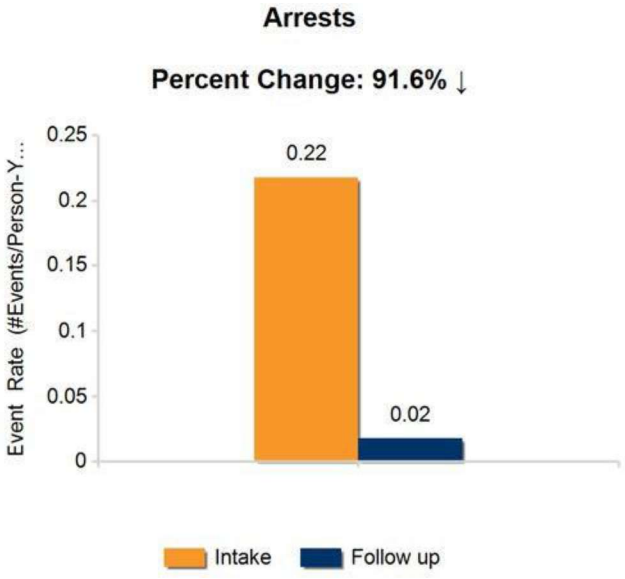
Overall, psychatric hospitalizations, use of mental health crisis facilities, arrests, and physical health emergencies reduced.



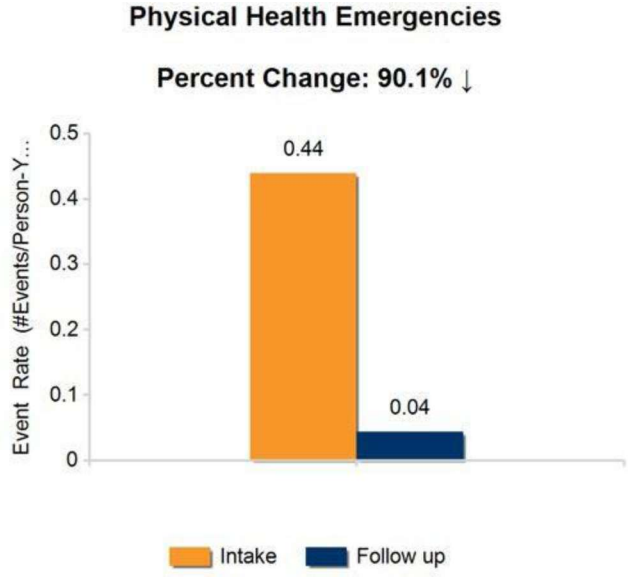

Hospitalizations decreased 21.7% from intake to follow-up.




Crisis decreased 35.2% from intake to follow-up.



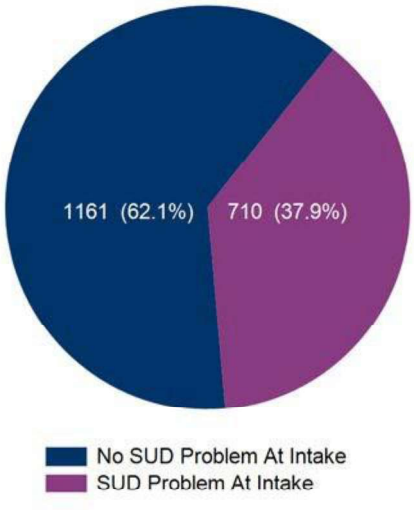

Arrests decreased 91.6% from intake to follow-up.

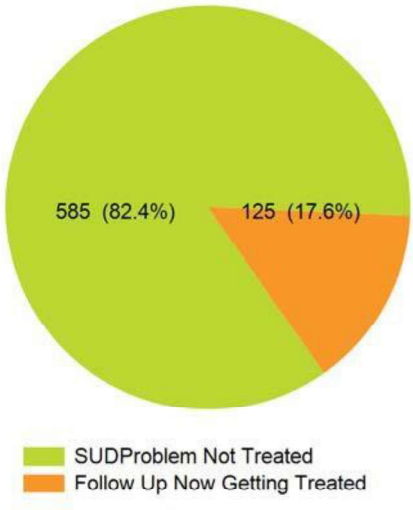



Phyiscal Helath Emergency visits decreased 90.1%.

## Outcomes: Substance Use

Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (37.9%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

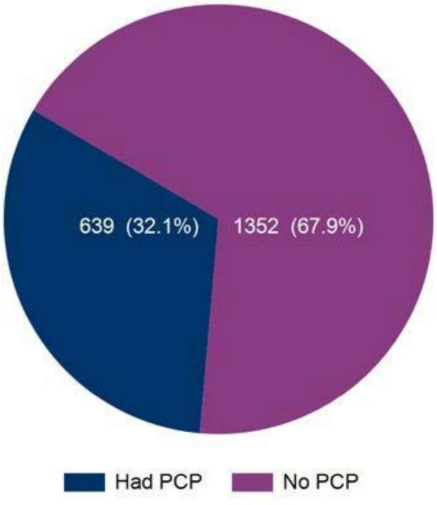



Follow-up: Based on follow-up data reported quarterly, 17.1% (100) of the 585 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 216 consumers not identified at intake were noted to have an SU problem on follow-up and 62.0% of them were reported to be in SU services on follow-up.

## Outcomes: Primary Care Physician

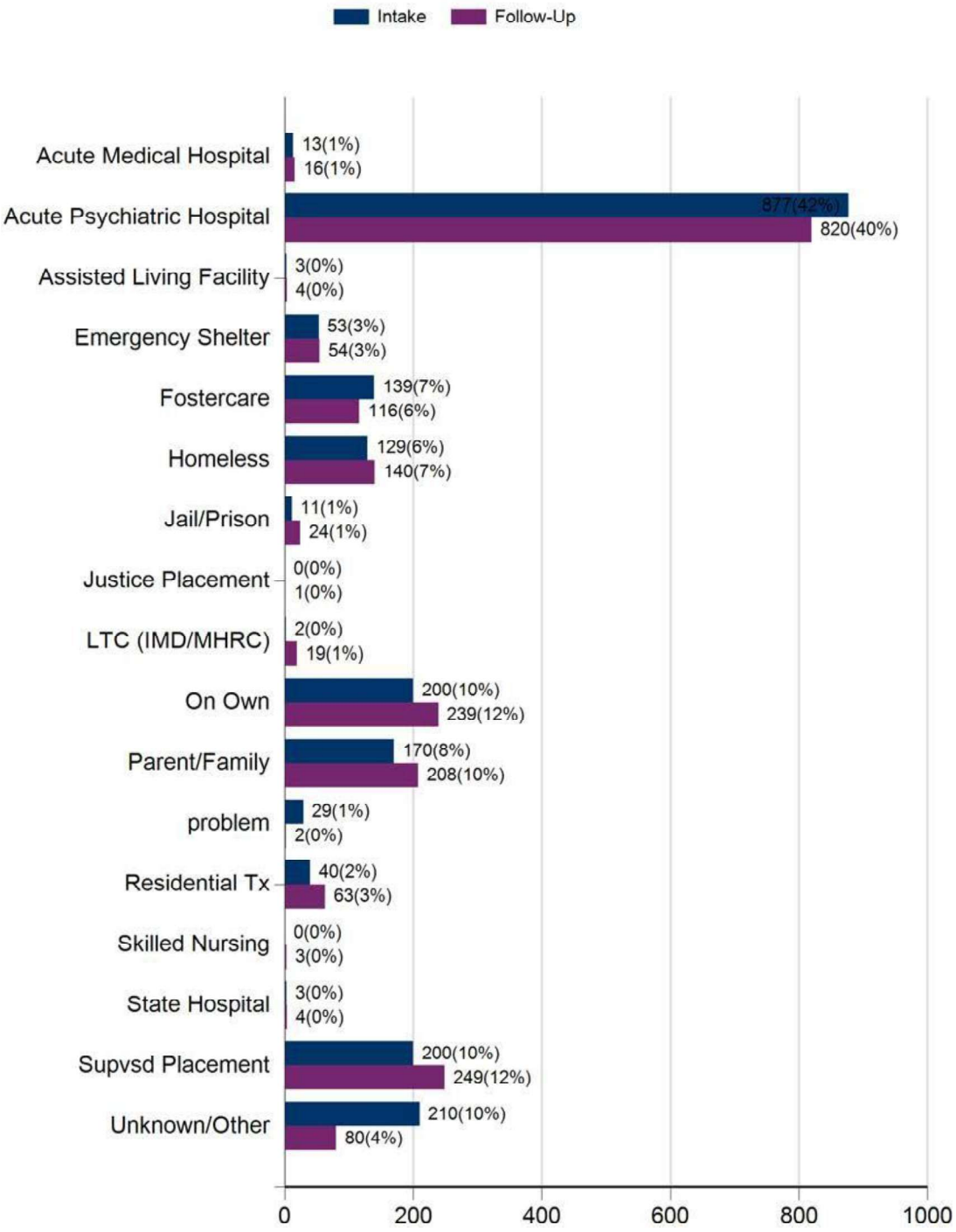
Intake: Most adults (67.9%) did not have a primary care physician (PCP) at intake.




Follow-up: Of the 1352 consumers that did not have a PCP at intake, 353 (26.1%) obtained a PCP while in the program.

## Outcomes: Residential

Overall, the adult FSP consumers had a decrease in the proportion homeless or in emergency shelter and an increase in the percentage of consumers living on their own. Residential settings was calculated using the residential category from intake to their latest residential status. The percentages below are for all reporting units.



## Outcomes: Residential Days

The following compares consumers' living arrangements in the year prior to FSP enrollment to their living arrangements while enrolled in the program. Specifically, the number of days spent in each setting in the year before enrollment is compared to the number of days they spent annually in each setting during enrollment. The goal of this analysis is to determine whether days in more stable settings during FSP participation had increased and days in less stable settings had decreased.

Baseline data was obtained from consumers' Partnership Assessment Form which includes the number of days consumers spent in each residential setting during the 12 months immediately prior to enrollment. Note that this 12 months preceded their **first** enrollment to any FSP program.

The number of days the consumers spent in each setting while enrolled in an FSP program was tracked through enrollment changes and residence changes noted on Key Event Tracking (KET) forms. When consumers re-enter an FSP program after a lapse in enrollment, their living arrangement is often noted on a KET form or new PAF, but if not, it was considered unknown. To accurately compare a year of pre-enrollment with a year of post enrollment, data for residential days during enrollment has been annualized.

| | 12 Months Prior to Enrollment | | Annualized Days During Enrollment | | |
|---|---|---|---|---|---|
| **Living Situation** | **# of Days** | **Count (n)** | **# of Days** | **Count (n)** | **Percent change (%)** |
| Acute Medical Hospital | 2,161 | 63 | 3,723 | 61 | 72% |
| Acute Psychiatric Hospital | 9,674 | 1036 | 109,808 | 1284 | 1035% |
| Assisted Living Facility | 1,162 | 4 | 1,923 | 11 | 65% |
| Emergency Shelter | 15,197 | 82 | 20,818 | 91 | 37% |
| Fostercare | 200 | 1 | - | 0 | -100% |
| Homeless | 120,864 | 386 | 35,806 | 220 | -70% |
| Jail/Prison | 10,764 | 120 | 3,838 | 40 | -64% |
| LTC (IMD/MHRC) | 20,864 | 68 | 5,898 | 35 | -72% |
| On Own | 154,816 | 470 | 98,312 | 289 | -36% |
| Parent/Family | 171,674 | 525 | 80,472 | 261 | -53% |
| Residential Tx | 7,359 | 89 | 16,549 | 111 | 125% |
| Skilled Nursing | 1,354 | 5 | 436 | 12 | -68% |
| State Hospital | 2,100 | 9 | 515 | 5 | -75% |
| Supervised Placement | 30,552 | 189 | 118,614 | 333 | 288% |
| Unknown/Other | 212,284 | 599 | 186,653 | 559 | -12% |

## FSP Adult demographics and Outcomes for: 33IPFA
## Served by this reporting unit: 261 Enrollment: 264

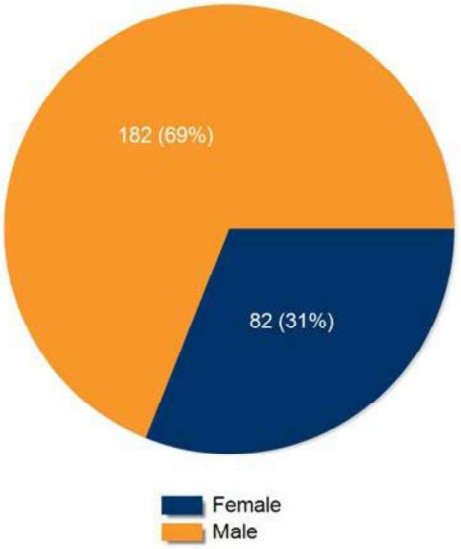
### Demographics

69% of consumers were male and 31% were female.

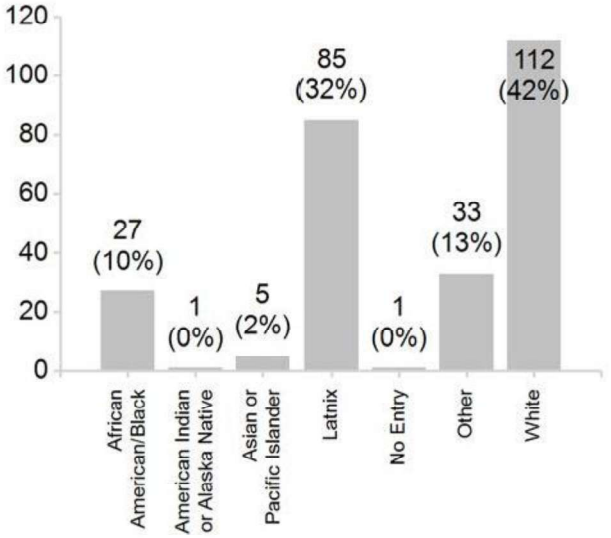
42% of consumers were White, 0% of consumers were Hispanic/Latinx and 10% of consumers were Black/African American.

25% of consumers were 40 to 49 years old.

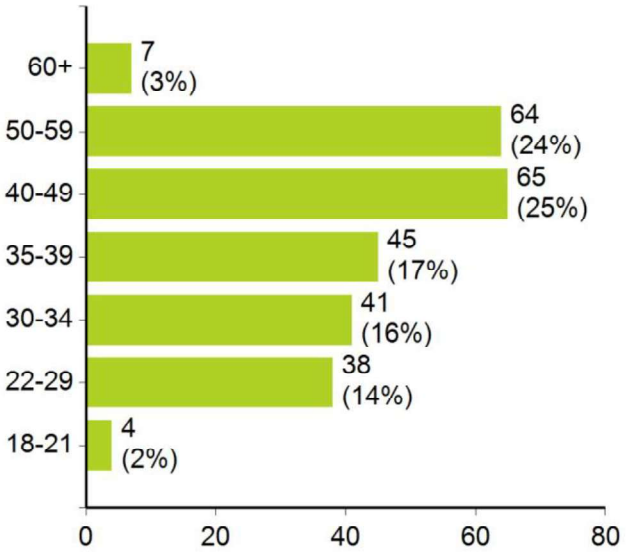
**Gender**



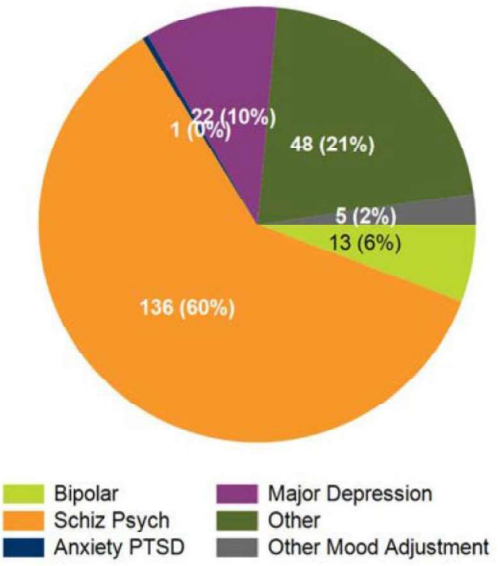

**Race/Ethnicity**




**Age**




**Diagnosis**



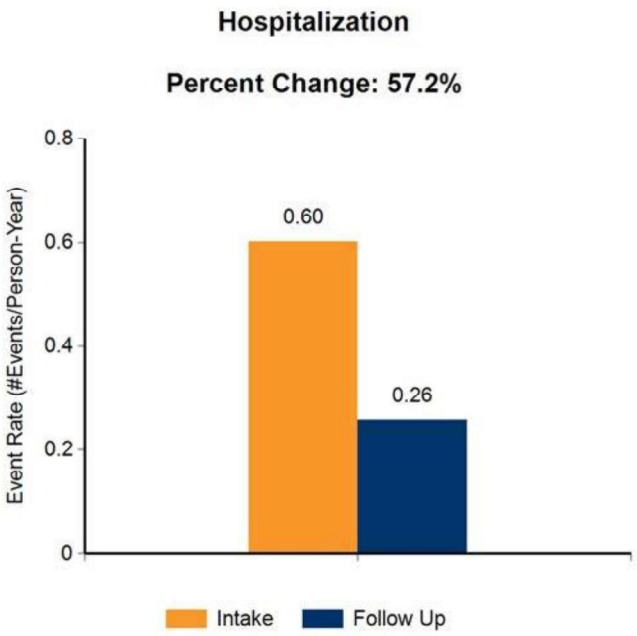
## Service Detail: 33IPFA

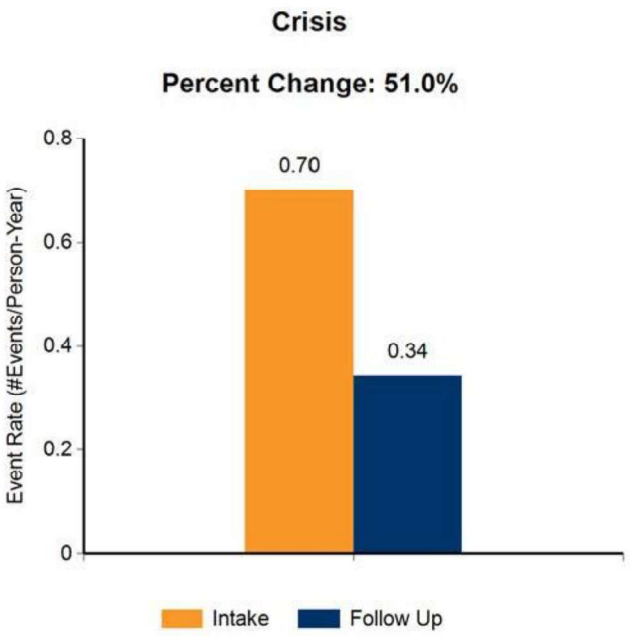
| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 7 (4%) | 11 (6%) | 8 (4%) | 6 (3%) | 11 (6%) | 12 (7%) | 5 (3%) | 11 (6%) | 10 (5%) | 7 (4%) | 6 (3%) | 9 (5%) |
| 2-3 | 29 (16%) | 29 (16%) | 23 (13%) | 30 (16%) | 22 (12%) | 29 (16%) | 21 (11%) | 25 (13%) | 41 (22%) | 22 (12%) | 21 (11%) | 33 (18%) |
| 4-7 | 60 (33%) | 66 (36%) | 75 (41%) | 69 (38%) | 70 (38%) | 66 (37%) | 73 (40%) | 65 (35%) | 68 (36%) | 69 (37%) | 77 (42%) | 78 (42%) |
| 8-13 | 45 (25%) | 46 (25%) | 54 (30%) | 47 (26%) | 54 (29%) | 45 (25%) | 47 (26%) | 55 (29%) | 42 (22%) | 53 (28%) | 50 (27%) | 43 (23%) |
| 14-19 | 19 (10%) | 16 (9%) | 9 (5%) | 17 (9%) | 18 (10%) | 15 (8%) | 22 (12%) | 17 (9%) | 6 (3%) | 22 (12%) | 12 (7%) | 11 (6%) |
| 20-25 | 17 (9%) | 11 (6%) | 6 (3%) | 10 (5%) | 6 (3%) | 8 (4%) | 7 (4%) | 7 (4%) | 12 (6%) | 6 (3%) | 7 (4%) | 7 (4%) |
| 26-31 | 2 (1%) | 3 (2%) | 6 (3%) | 3 (2%) | 4 (2%) | 1 (1%) | 6 (3%) | 5 (3%) | 4 (2%) | 2 (1%) | 3 (2%) | 1 (1%) |
| 32+ | 2 (1%) | 2 (1%) | 2 (1%) | 2 (1%) | 0 (0%) | 4 (2%) | 2 (1%) | 2 (1%) | 4 (2%) | 5 (3%) | 7 (4%) | 4 (2%) |
| Monthly Total | 181 | 184 | 183 | 184 | 185 | 180 | 183 | 187 | 187 | 186 | 183 | 186 |

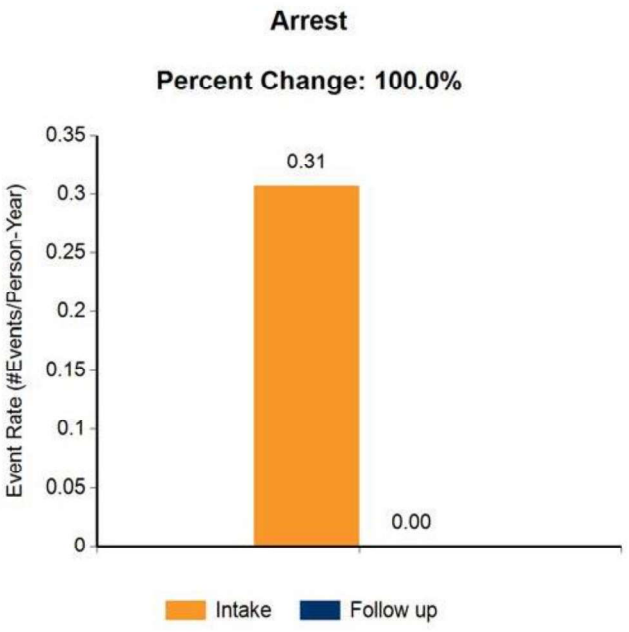
| Type of Service | # of Adult | % of Adult | # of Svcs | Avg. # Svcs |
|---|---|---|---|---|
| Assessment Services | 56 | 4% | 62 | 1.11 |
| Case Management | 251 | 16% | 3,813 | 15.19 |
| Crisis | 17 | 1% | 27 | 1.59 |
| Family Therapy | 13 | 1% | 39 | 3.00 |
| Individual Therapy | 123 | 8% | 1,714 | 13.93 |
| Medication MD Services | 233 | 15% | 1,147 | 4.92 |
| Medication Therapeutic Services | 213 | 14% | 1,736 | 8.15 |
| Mental Health Services-Group | 133 | 9% | 3,722 | 27.98 |
| Mental Health Services-Individual | 249 | 16% | 4,465 | 17.93 |
| Non Face to Face MD | 75 | 5% | 107 | 1.43 |
| Peer MH Education Groups | 85 | 5% | 1,168 | 13.74 |
| Peer MH Therapeutic Activity | 87 | 6% | 797 | 9.16 |
| Psychiatric Assessment | 21 | 1% | 21 | 1.00 |

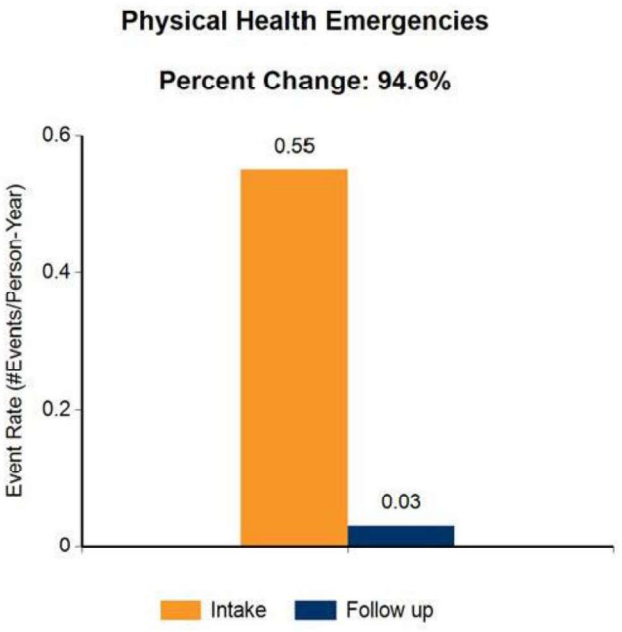
## Outcomes for 33IPFA

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

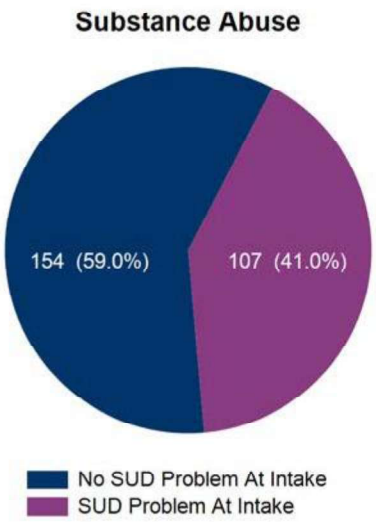


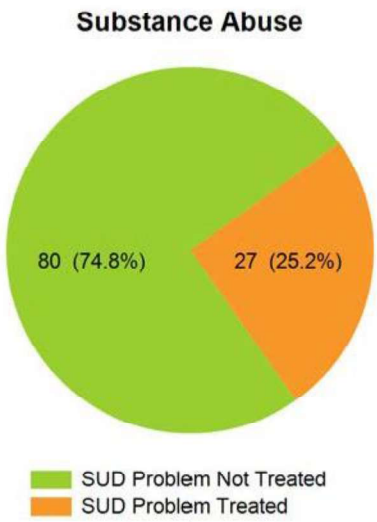



## Outcomes: Substance Use (33IPFA)

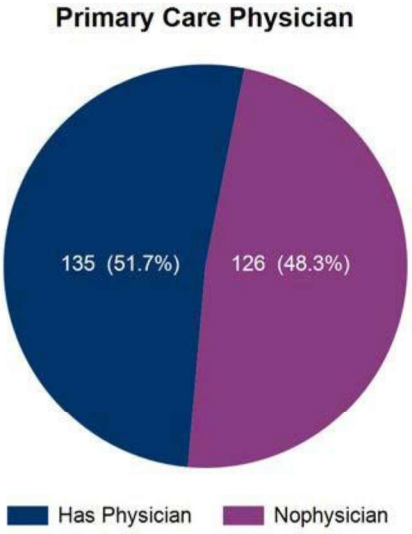



Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (41.0%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 61.3% (49) of the 80 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 55 consumers not identified at intake were noted to have an SU problem on follow-up and 61.0% of them were reported to be in SU services on follow-up.

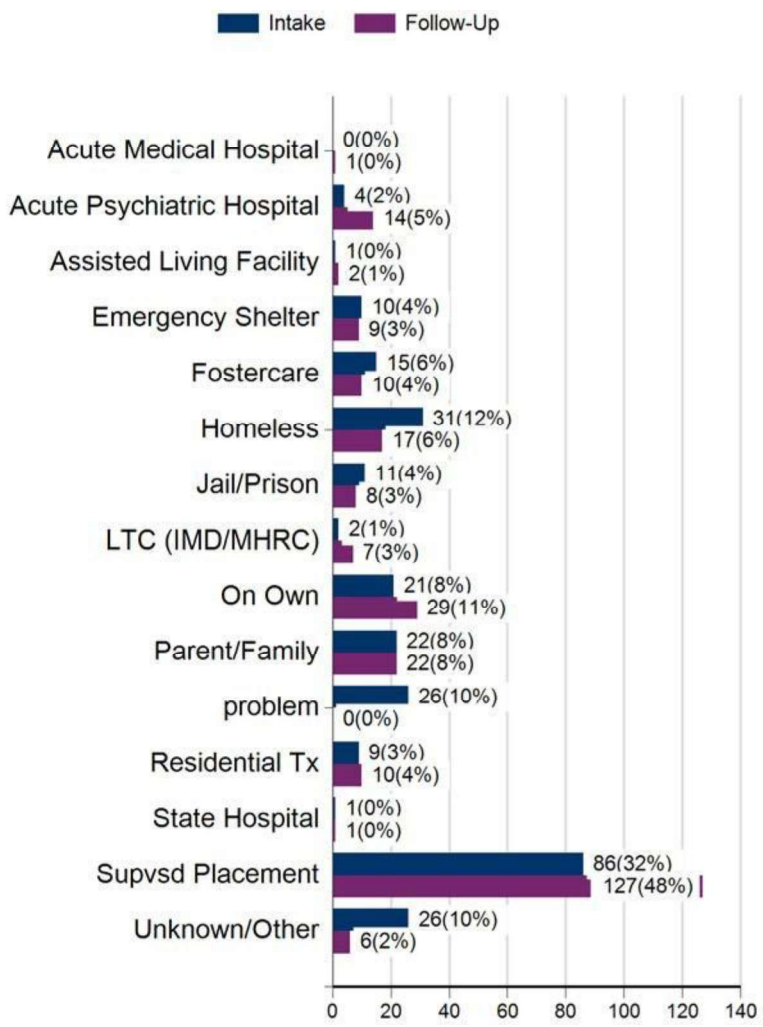
## Outcomes: Primary Care Physician (33IPFA)




Intake: Most adults (48.3%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 126 consumers that did not have a PCP at intake, 120 (95.0%) obtained a PCP while in the program.

## Outcomes: Residential & Discontinuance (33IPFA)




| Discontinuation Reason | Count | % |
|---|---|---|
| Deceased | 3 | 4% |
| Justice system | 2 | 3% |
| Met goals | 8 | 12% |
| Moved out of county/area | 15 | 22% |
| Needs residential care | 17 | 25% |
| Partner cannot be located | 12 | 18% |
| Partner left program | 8 | 12% |
| Target criteria not met | 3 | 4% |
| **Total** | **68** | **100%** |

## Length of FSP Partnership for: 33IPFA

| Adult Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| >= 1 Year and < 2 Years | 24 | 27 | 51 | 19.32% |
| >= 2 Years and <3 Years | 12 | 24 | 36 | 13.64% |
| >= 3 Years and < 4 Years | 4 | 53 | 57 | 21.59% |
| >= 4 Years and < 5 years | 1 | 2 | 3 | 1.14% |
| >= 90 days and < 1 Year | 31 | 55 | 86 | 32.58% |
| >=5 Years and < 6 years | 0 | 4 | 4 | 1.52% |
| >=6 Years+ | 0 | 3 | 3 | 1.14% |
| Under 90 days | 11 | 13 | 24 | 9.09% |
| **Total Consumer Enrollments** | **83** | **181** | **264** | |

## FSP Adult demographics and Outcomes for: 3301FA
## Served by this reporting unit: 78 Enrollment: 80

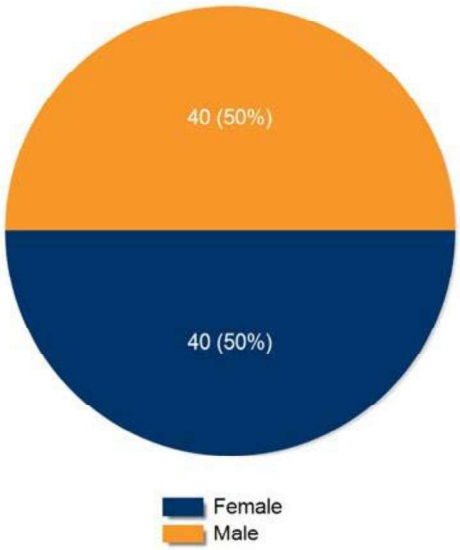
### Demographics

50% of consumers were male and 50% were female.

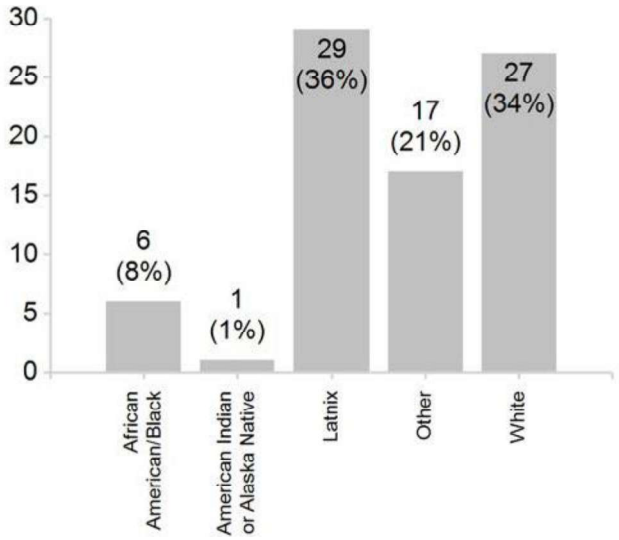
34% of consumers were White, 0% of consumers were Hispanic/Latinx and 8% of consumers were Black/African American.

24% of consumers were 40 to 49 years old.

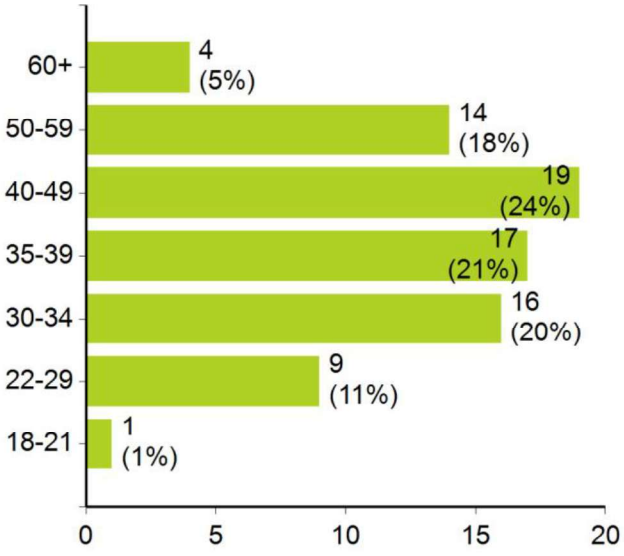
**Gender**



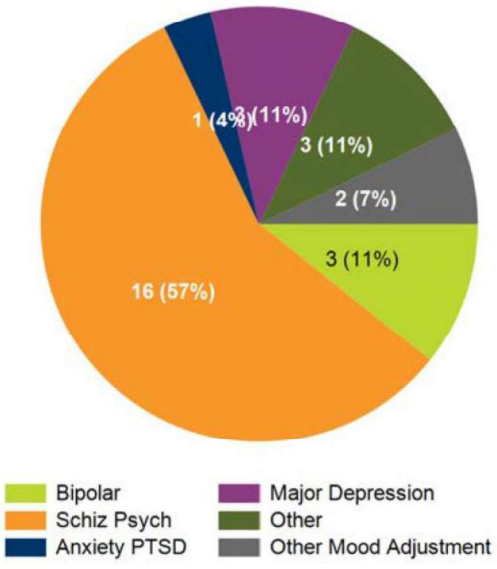

**Race/Ethnicity**




**Age**




**Diagnosis**



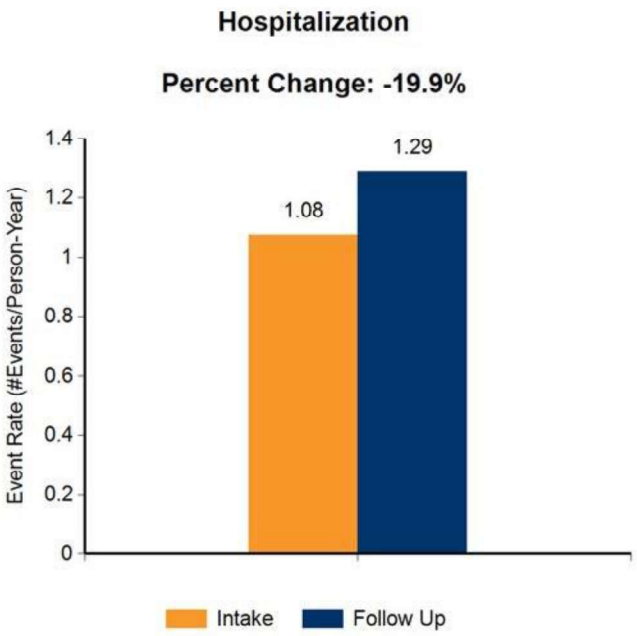
## Service Detail: 3301FA

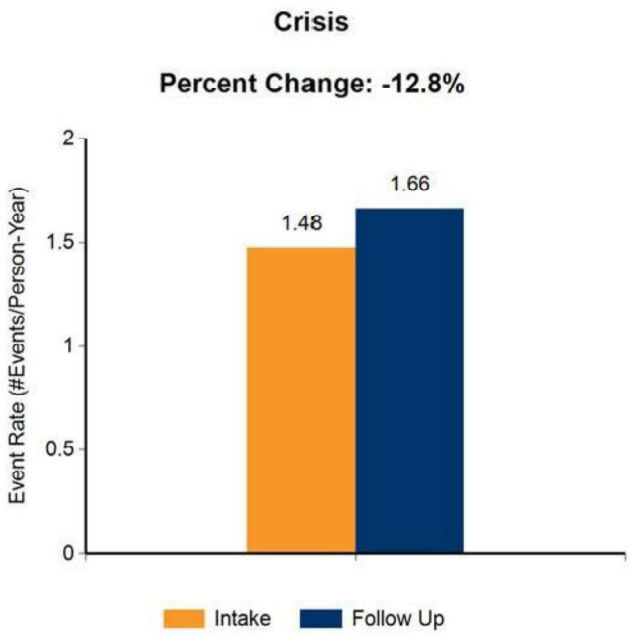
| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 2 (67%) | 2 (67%) | 0 (0%) | 2 (67%) | 1 (50%) | 2 (100%) | 1 (50%) | 5 (71%) | 2 (67%) | 2 (67%) | 4 (50%) | 15 (29%) |
| 2-3 | 1 (33%) | 0 (0%) | 3 (100%) | 1 (33%) | 0 (0%) | 0 (0%) | 0 (0%) | 2 (29%) | 1 (33%) | 0 (0%) | 2 (25%) | 14 (27%) |
| 4-7 | 0 (0%) | 1 (33%) | 0 (0%) | 0 (0%) | 1 (50%) | 0 (0%) | 1 (50%) | 0 (0%) | 0 (0%) | 1 (33%) | 0 (0%) | 19 (37%) |
| 8-13 | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (13%) | 3 (6%) |
| 14-19 | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (13%) | 1 (2%) |
| Monthly Total | 3 | 3 | 3 | 3 | 2 | 2 | 2 | 7 | 3 | 3 | 8 | 52 |

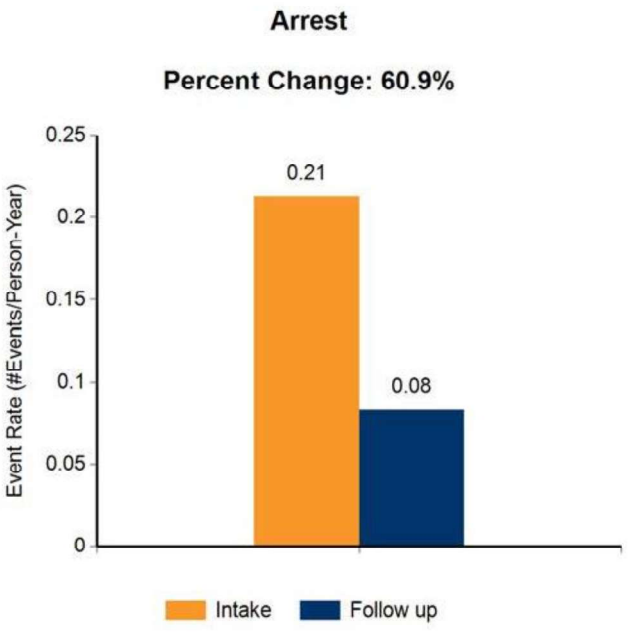
| Type of Service | # of Adult | % of Adult | # of Svcs | Avg. # Svcs |
|---|---|---|---|---|
| Assessment Services | 2 | 2% | 2 | 1.00 |
| Case Management | 41 | 34% | 74 | 1.80 |
| Individual Therapy | 9 | 8% | 46 | 5.11 |
| Medication MD Services | 8 | 7% | 11 | 1.38 |
| Medication Therapeutic Services | 10 | 8% | 15 | 1.50 |
| Mental Health Services-Group | 20 | 17% | 61 | 3.05 |
| Mental Health Services-Individual | 18 | 15% | 31 | 1.72 |
| Non Face to Face MD | 2 | 2% | 5 | 2.50 |
| Peer MH Education Groups | 3 | 3% | 10 | 3.33 |
| Peer MH Engagement | 2 | 2% | 2 | 1.00 |
| Psychiatric Assessment | 4 | 3% | 4 | 1.00 |

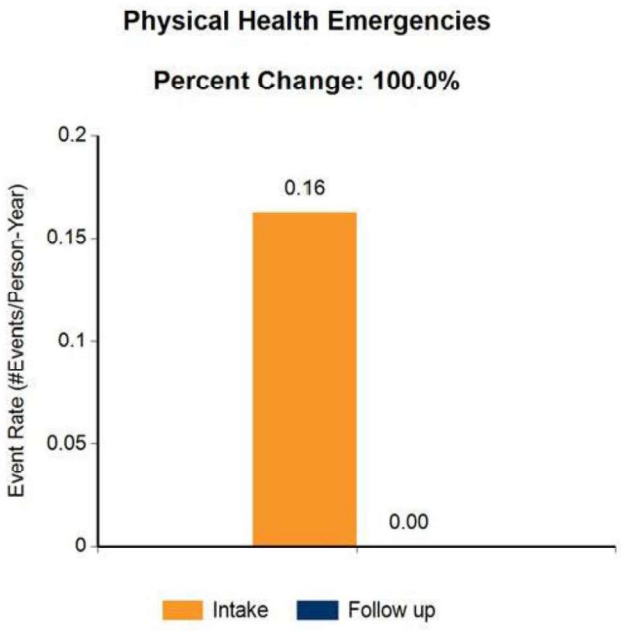
## Outcomes for 3301FA

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

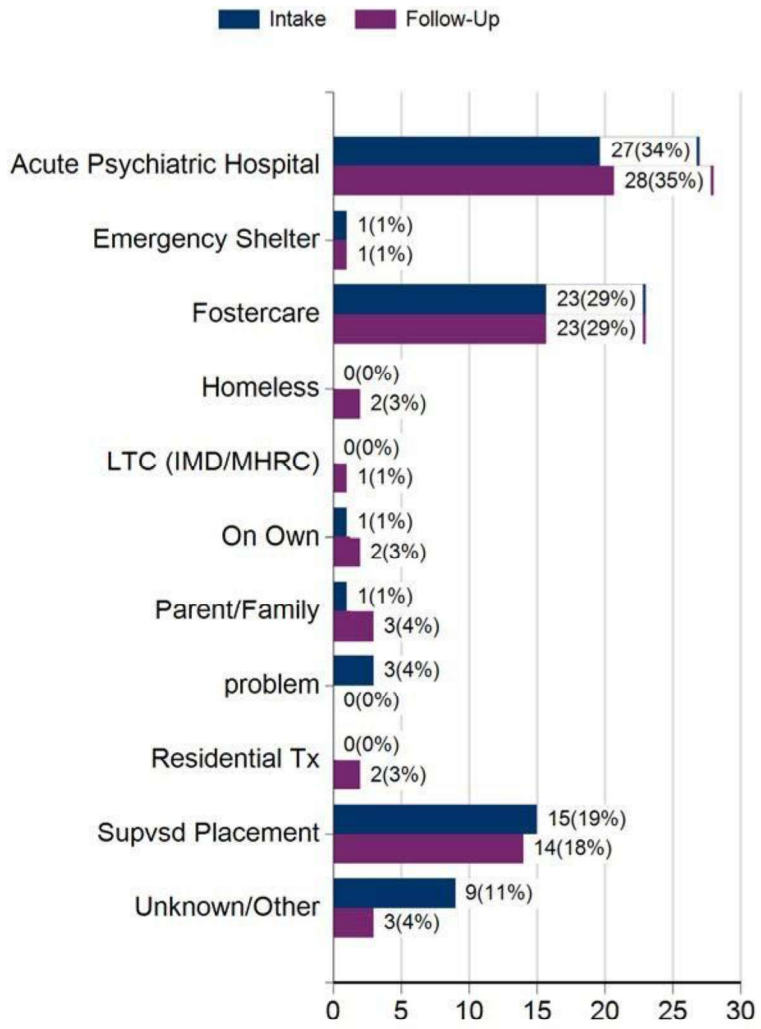


## Outcomes: Residential & Discontinuance (3301FA)

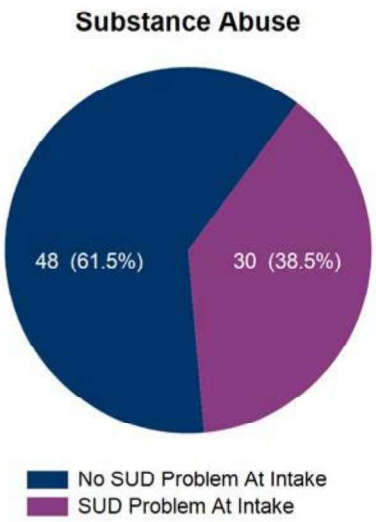


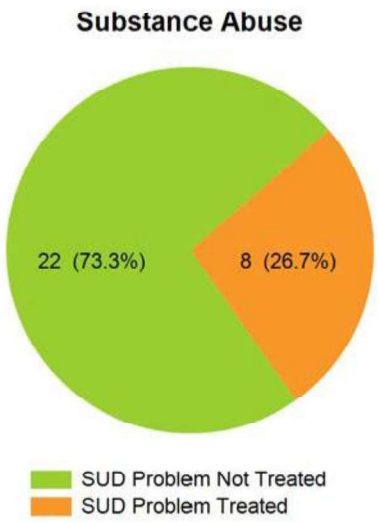

| Discontinuation Reason | Count | % |
|---|---|---|
| **Met goals** | 1 | 10% |
| **Partner cannot be located** | 6 | 60% |
| **Partner left program** | 3 | 30% |
| **Total** | **10** | **100%** |

## Length of FSP Partnership for: 3301FA

| Adult Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| >= 1 Year and < 2 Years | 1 | 0 | 1 | 1.25% |
| >= 2 Years and <3 Years | 1 | 2 | 3 | 3.75% |
| >= 3 Years and < 4 Years | 0 | 1 | 1 | 1.25% |
| >= 90 days and < 1 Year | 8 | 4 | 12 | 15.00% |
| Under 90 days | 2 | 61 | 63 | 78.75% |
| **Total Consumer Enrollments** | **12** | **68** | **80** | |

## Outcomes: Substance Use (3301FA)

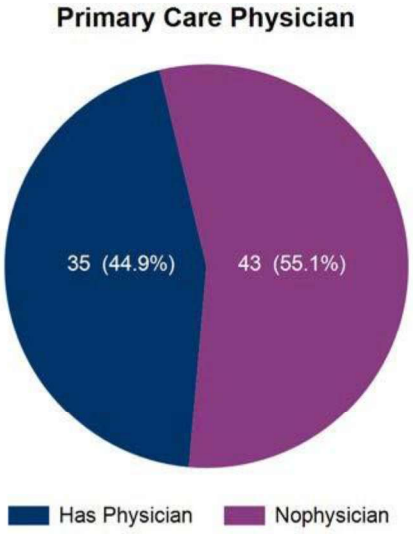



Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (38.5%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 4.5% (1) of the 22 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 0 consumers not identified at intake were noted to have an SU problem on follow-up and 5.0% of them were reported to be in SU services on follow-up.

## Outcomes: Primary Care Physician (3301FA)




Intake: Most adults (55.1%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 43 consumers that did not have a PCP at intake, 4 (9.0%) obtained a PCP while in the program.

## FSP Adult demographics and Outcomes for: 3301FP
## Served by this reporting unit: 427 Enrollment: 457

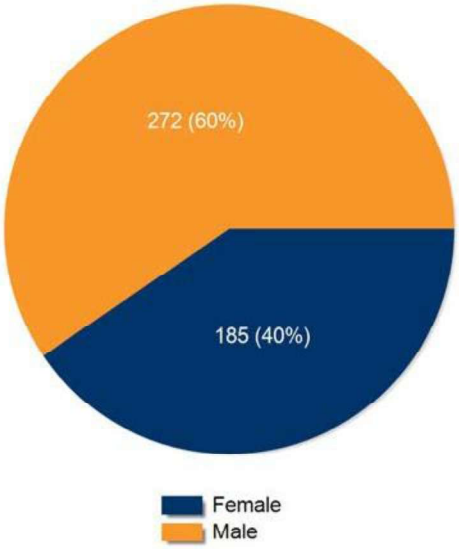
### Demographics

60% of consumers were male and 40% were female.

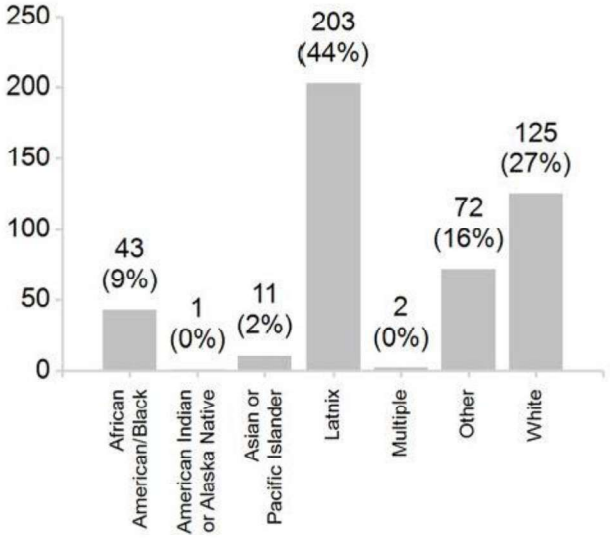
27% of consumers were White, 0% of consumers were Hispanic/Latinx and 9% of consumers were Black/African American.

20% of consumers were 40 to 49 years old.

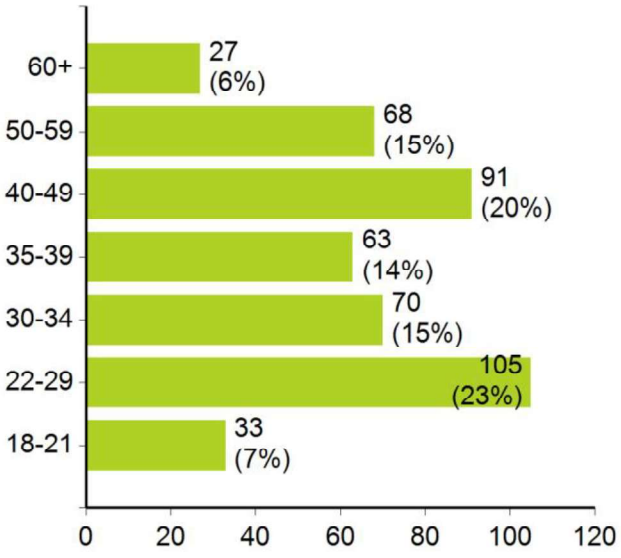
**Gender**



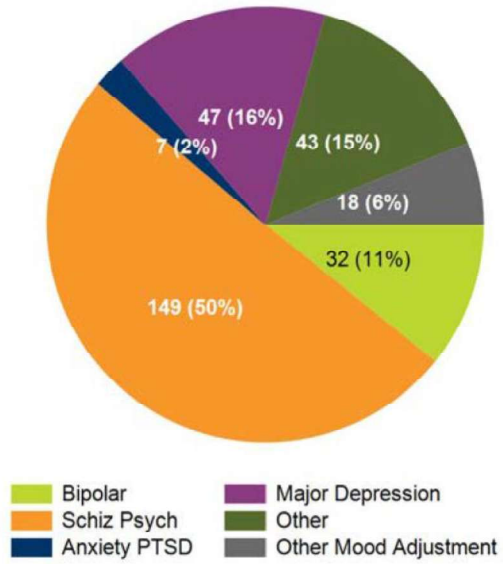

**Race/Ethnicity**




**Age**




**Diagnosis**



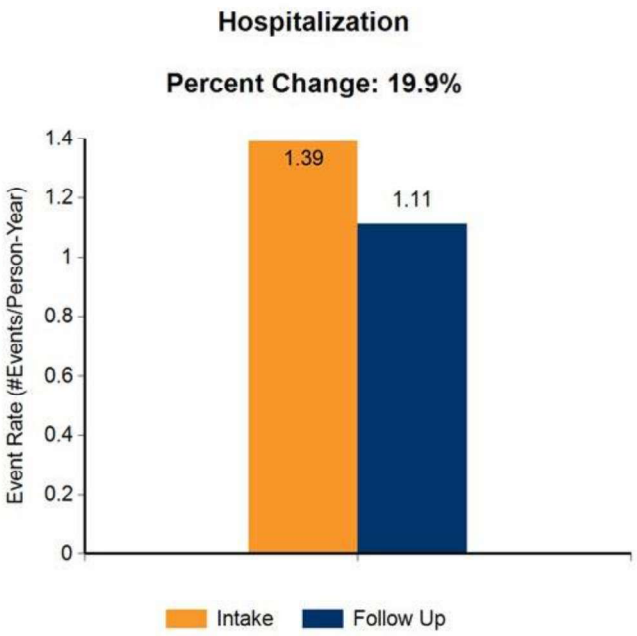
## Service Detail: 3301FP

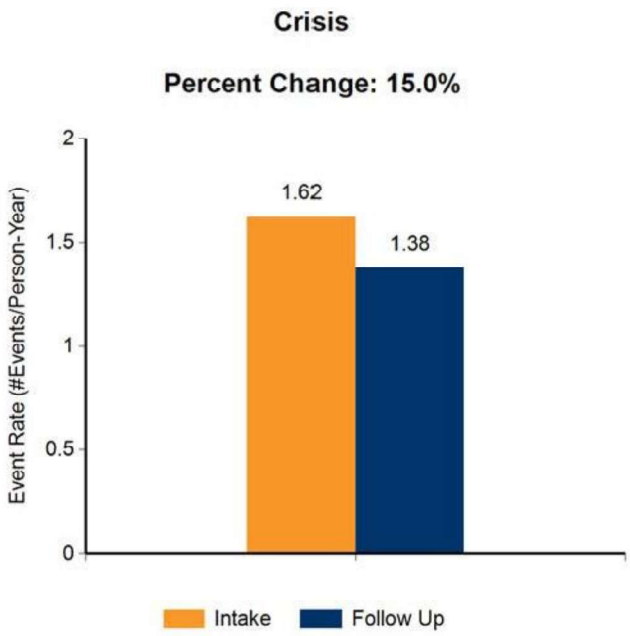
| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 50 (41%) | 56 (43%) | 15 (16%) | 32 (30%) | 30 (30%) | 42 (39%) | 63 (48%) | 29 (32%) | 44 (39%) | 15 (21%) | 26 (28%) | 23 (66%) |
| 2-3 | 27 (22%) | 30 (23%) | 32 (35%) | 33 (31%) | 30 (30%) | 32 (30%) | 32 (24%) | 26 (29%) | 39 (35%) | 22 (31%) | 29 (32%) | 10 (29%) |
| 4-7 | 18 (15%) | 11 (8%) | 19 (21%) | 16 (15%) | 14 (14%) | 15 (14%) | 18 (14%) | 15 (16%) | 10 (9%) | 13 (19%) | 13 (14%) | 2 (6%) |
| 8-13 | 15 (12%) | 17 (13%) | 9 (10%) | 11 (10%) | 15 (15%) | 10 (9%) | 8 (6%) | 9 (10%) | 11 (10%) | 14 (20%) | 11 (12%) | 0 (0%) |
| 14-19 | 6 (5%) | 10 (8%) | 11 (12%) | 8 (8%) | 7 (7%) | 5 (5%) | 6 (5%) | 9 (10%) | 5 (4%) | 4 (6%) | 6 (7%) | 0 (0%) |
| 20-25 | 4 (3%) | 3 (2%) | 3 (3%) | 4 (4%) | 3 (3%) | 3 (3%) | 5 (4%) | 3 (3%) | 3 (3%) | 2 (3%) | 2 (2%) | 0 (0%) |
| 26-31 | 1 (1%) | 2 (2%) | 2 (2%) | 1 (1%) | 1 (1%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 4 (4%) | 0 (0%) |
| 32+ | 0 (0%) | 2 (2%) | 0 (0%) | 1 (1%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (1%) | 0 (0%) |
| Monthly Total | 121 | 131 | 91 | 106 | 100 | 107 | 132 | 91 | 112 | 70 | 92 | 35 |

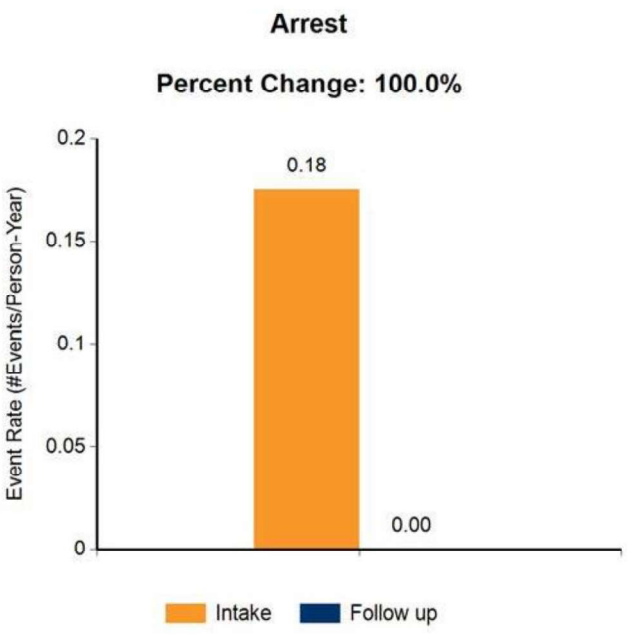
| Type of Service | # of Adult | % of Adult | # of Svcs | Avg. # Svcs |
|---|---|---|---|---|
| Assessment Services | 14 | 3% | 14 | 1.00 |
| Case Management | 426 | 79% | 2,967 | 6.96 |
| Crisis | 4 | 1% | 5 | 1.25 |
| Individual Therapy | 9 | 2% | 162 | 18.00 |
| Mental Health Services-Group | 39 | 7% | 1,960 | 50.26 |
| Mental Health Services-Individual | 44 | 8% | 685 | 15.57 |

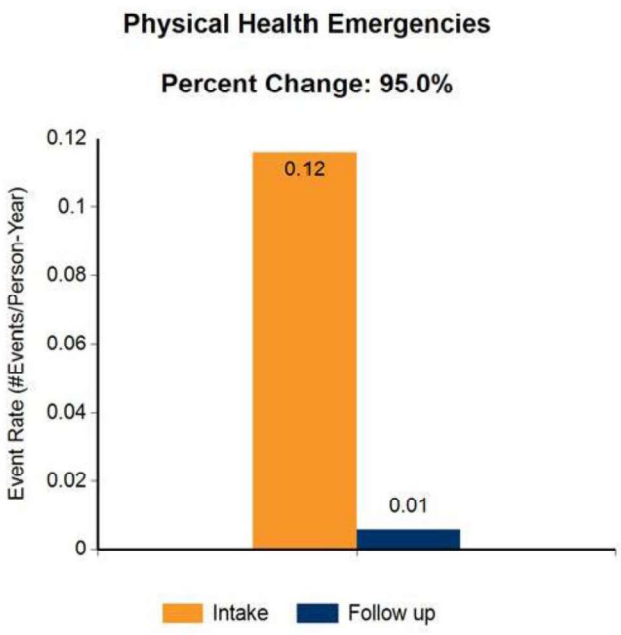
## Outcomes for 3301FP

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

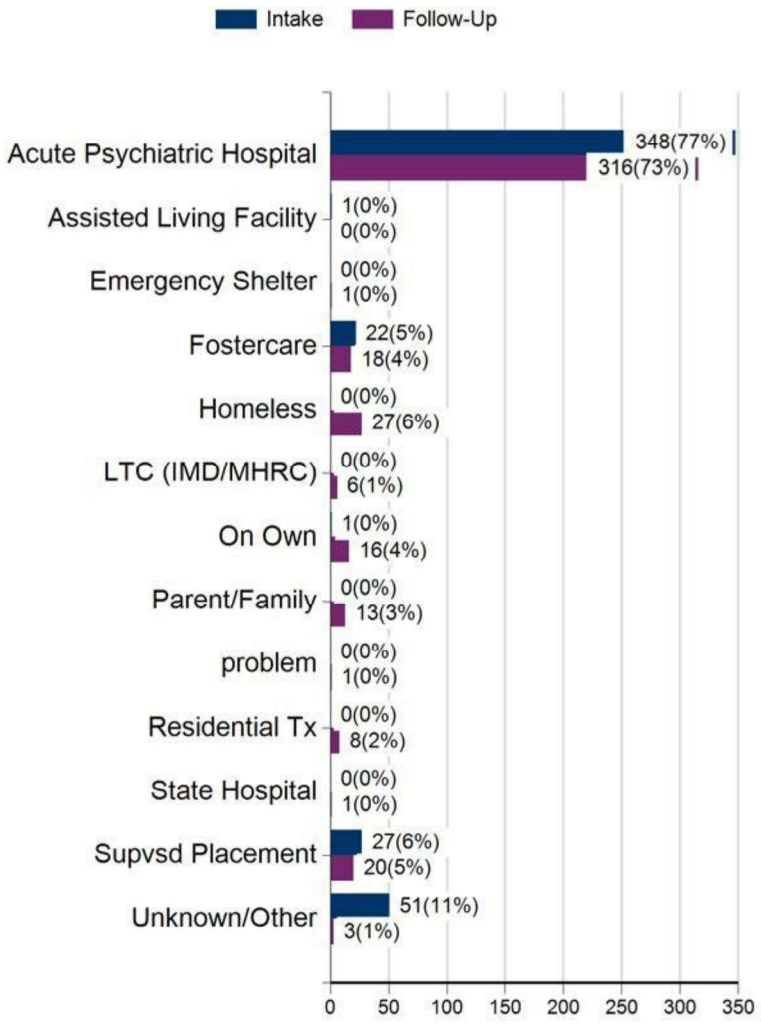


## Outcomes: Residential & Discontinuance (3301FP)

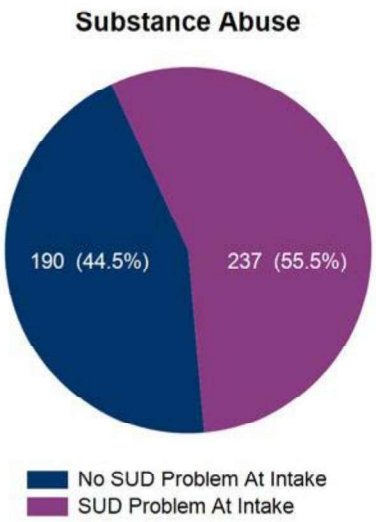


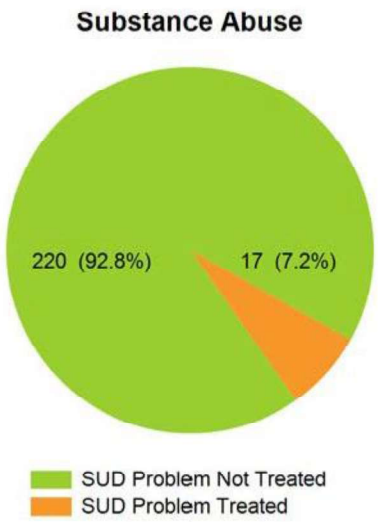

| Discontinuation Reason | Count | % |
|---|---|---|
| **Met goals** | 436 | 99% |
| **Moved out of county/area** | 2 | 0% |
| **Needs residential care** | 1 | 0% |
| **Other** | 1 | 0% |
| **Total** | **440** | **100%** |

## Length of FSP Partnership for: 3301FP

| Adult Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| >= 1 Year and < 2 Years | 12 | 5 | 17 | 3.72% |
| >= 2 Years and <3 Years | 22 | 3 | 25 | 5.47% |
| >= 90 days and < 1 Year | 116 | 14 | 130 | 28.45% |
| Under 90 days | 271 | 14 | 285 | 62.36% |
| **Total Consumer Enrollments** | **421** | **36** | **457** | |

## Outcomes: Substance Use (3301FP)

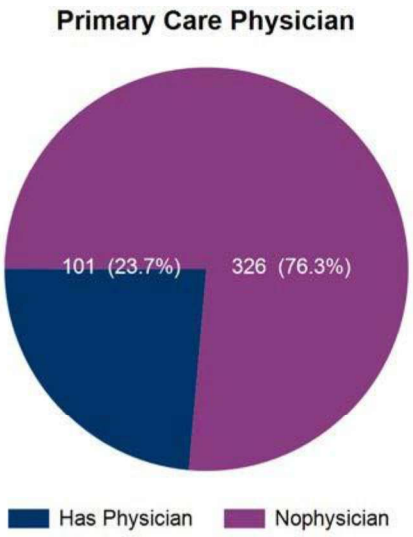



Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (55.5%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 1.8% (4) of the 220 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 6 consumers not identified at intake were noted to have an SU problem on follow-up and 2.0% of them were reported to be in SU services on follow-up.

## Outcomes: Primary Care Physician (3301FP)




Intake: Most adults (76.3%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 326 consumers that did not have a PCP at intake, 18 (6.0%) obtained a PCP while in the program.

## FSP Adult demographics and Outcomes for: 3385FA
## Served by this reporting unit: 65 Enrollment: 65

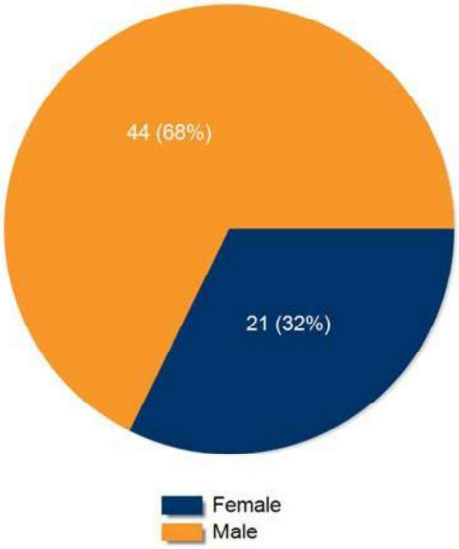
### Demographics

68% of consumers were male and 32% were female.

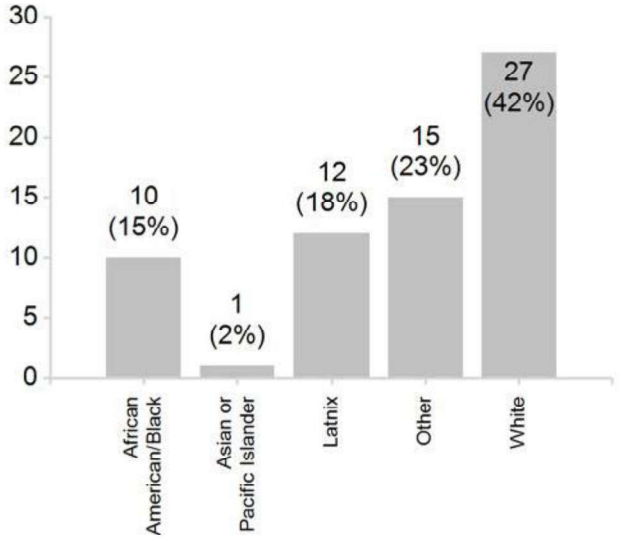
42% of consumers were White, 0% of consumers were Hispanic/Latinx and 15% of consumers were Black/African American.

22% of consumers were 40 to 49 years old.

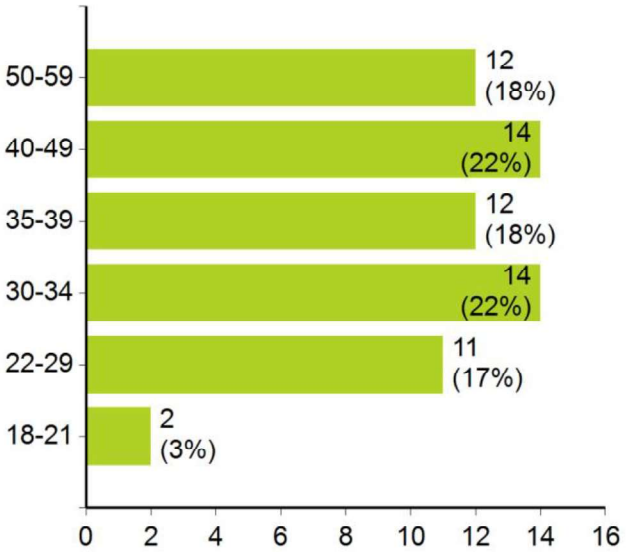
**Gender**



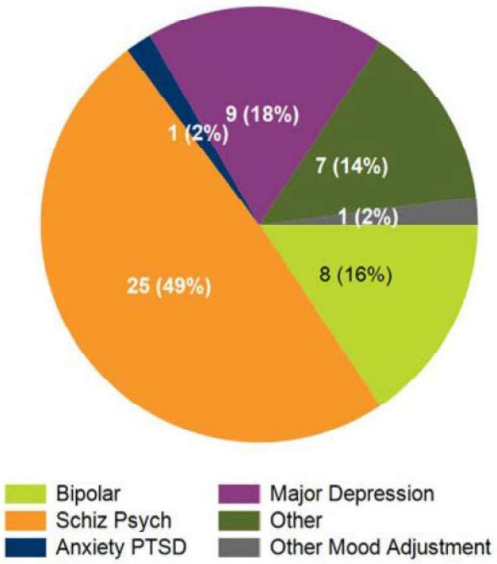

**Race/Ethnicity**




**Age**




**Diagnosis**



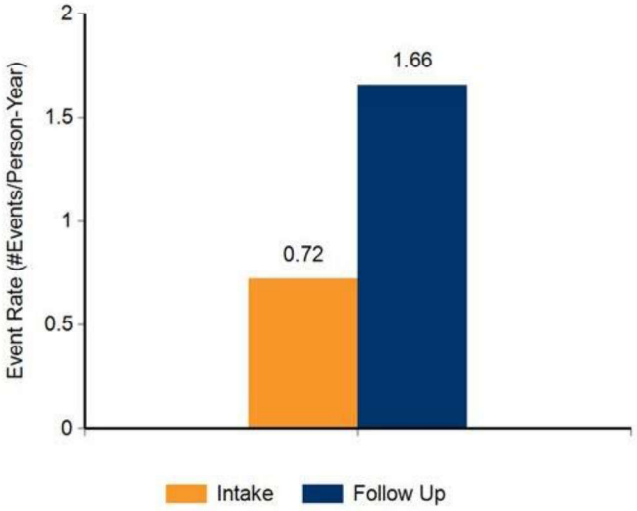
## Service Detail: 3385FA

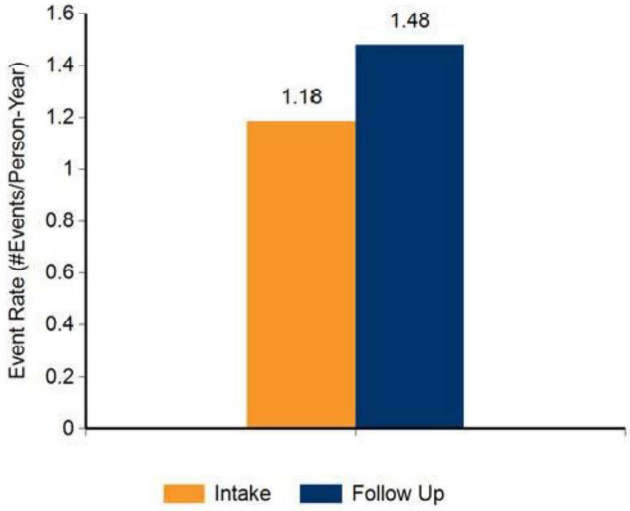
| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 3 (25%) | 2 (13%) | 3 (17%) | 5 (21%) | 3 (14%) | 1 (5%) | 5 (22%) | 8 (32%) | 9 (33%) | 8 (27%) | 3 (14%) | 3 (18%) |
| 2-3 | 2 (17%) | 6 (38%) | 5 (28%) | 5 (21%) | 1 (5%) | 9 (45%) | 9 (39%) | 8 (32%) | 8 (30%) | 9 (30%) | 6 (29%) | 6 (35%) |
| 4-7 | 5 (42%) | 4 (25%) | 3 (17%) | 6 (25%) | 10 (48%) | 5 (25%) | 2 (9%) | 4 (16%) | 5 (19%) | 9 (30%) | 9 (43%) | 6 (35%) |
| 8-13 | 1 (8%) | 2 (13%) | 5 (28%) | 6 (25%) | 5 (24%) | 3 (15%) | 4 (17%) | 4 (16%) | 4 (15%) | 2 (7%) | 2 (10%) | 2 (12%) |
| 14-19 | 1 (8%) | 1 (6%) | 0 (0%) | 0 (0%) | 2 (10%) | 2 (10%) | 2 (9%) | 1 (4%) | 1 (4%) | 2 (7%) | 0 (0%) | 0 (0%) |
| 20-25 | 0 (0%) | 1 (6%) | 1 (6%) | 1 (4%) | 0 (0%) | 0 (0%) | 1 (4%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| 26-31 | 0 (0%) | 0 (0%) | 0 (0%) | 1 (4%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| 32+ | 0 (0%) | 0 (0%) | 1 (6%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (5%) | 0 (0%) |
| Monthly Total | 12 | 16 | 18 | 24 | 21 | 20 | 23 | 25 | 27 | 30 | 21 | 17 |

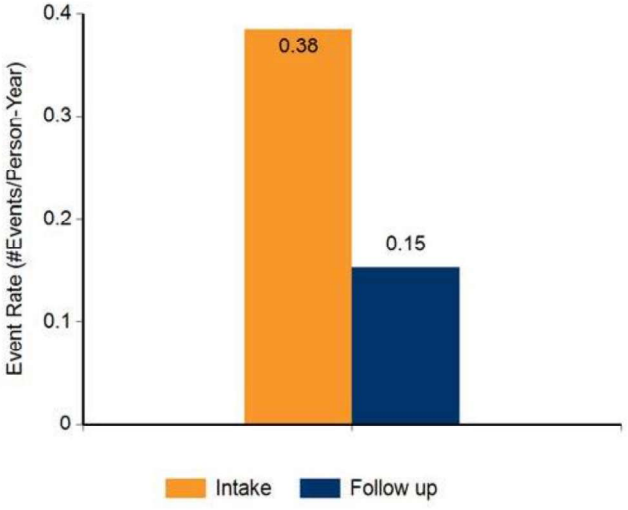
| Type of Service | # of Adult | % of Adult | # of Svcs | Avg. # Svcs |
|---|---|---|---|---|
| Assessment Services | 12 | 6% | 12 | 1.00 |
| Case Management | 44 | 21% | 490 | 11.14 |
| Collateral Services | 1 | 0% | 1 | 1.00 |
| Crisis | 7 | 3% | 18 | 2.57 |
| Family Therapy | 1 | 0% | 2 | 2.00 |
| Individual Therapy | 18 | 9% | 114 | 6.33 |
| Medication MD Services | 20 | 10% | 61 | 3.05 |
| Medication Therapeutic Services | 29 | 14% | 174 | 6.00 |
| Mental Health Services-Individual | 31 | 15% | 241 | 7.77 |
| Non Face to Face MD | 9 | 4% | 14 | 1.56 |
| Peer MH Education Groups | 5 | 2% | 15 | 3.00 |
| Peer MH Engagement | 9 | 4% | 11 | 1.22 |
| Peer MH Therapeutic Activity | 20 | 10% | 169 | 8.45 |
| Psychiatric Assessment | 1 | 0% | 1 | 1.00 |

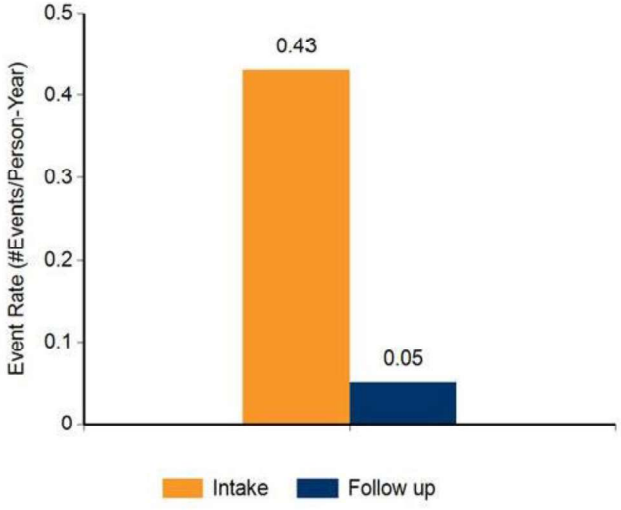
## Outcomes for 3385FA

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

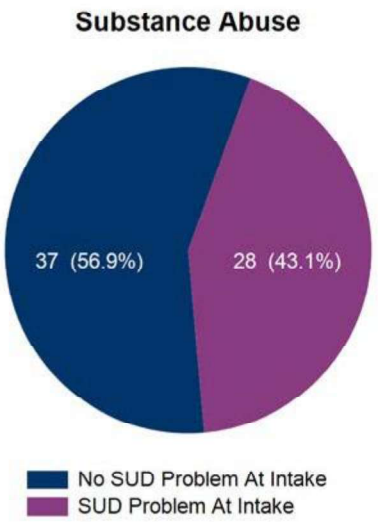


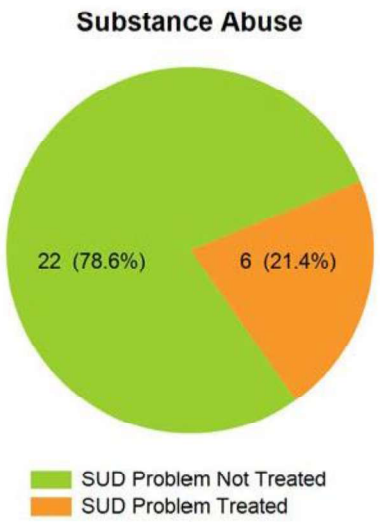



## Outcomes: Substance Use (3385FA)

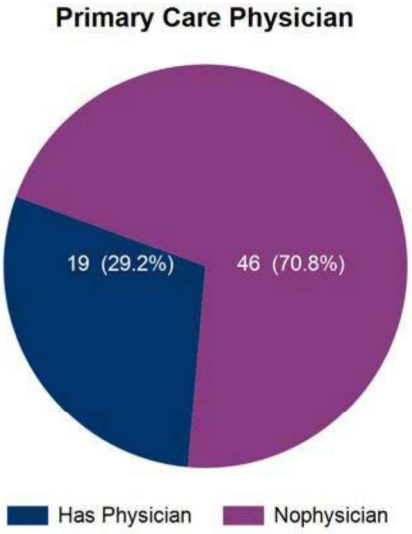



Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (43.1%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 9.1% (2) of the 22 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 5 consumers not identified at intake were noted to have an SU problem on follow-up and 9.0% of them were reported to be in SU services on follow-up.

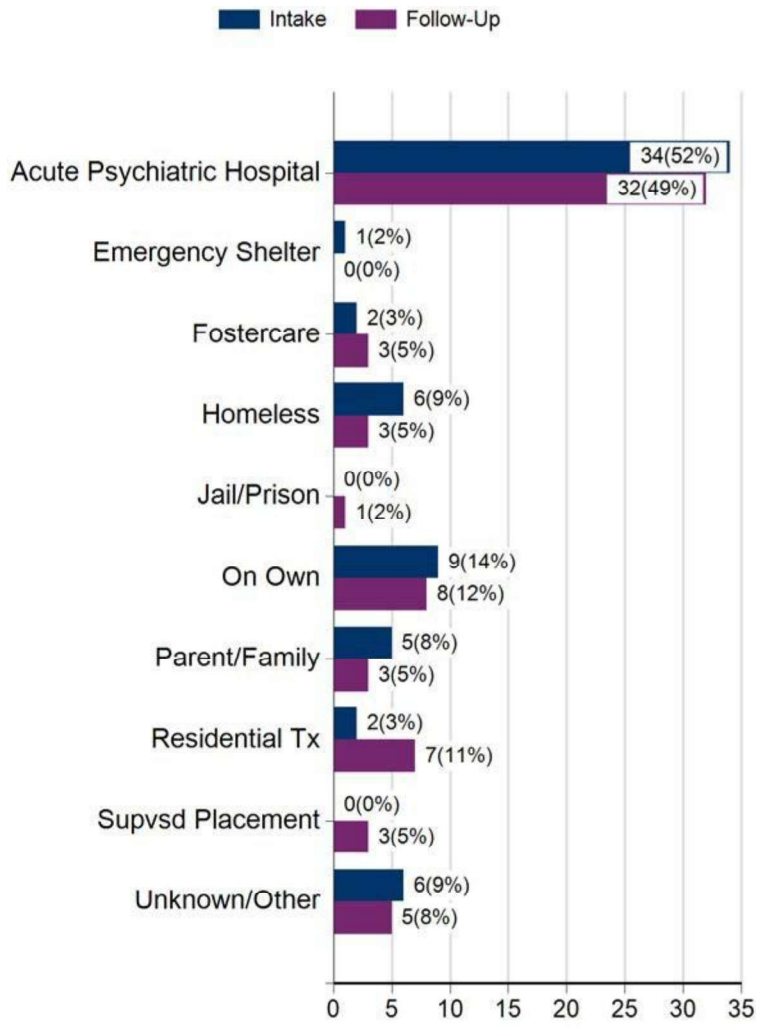
## Outcomes: Primary Care Physician (3385FA)




Intake: Most adults (70.8%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 46 consumers that did not have a PCP at intake, 12 (26.0%) obtained a PCP while in the program.

## Outcomes: Residential & Discontinuance (3385FA)




| Discontinuation Reason | Count | % |
|---|---|---|
| Deceased | 1 | 3% |
| Justice system | 3 | 8% |
| Met goals | 2 | 5% |
| Moved out of county/area | 3 | 8% |
| Needs residential care | 1 | 3% |
| Partner cannot be located | 11 | 28% |
| Partner left program | 12 | 31% |
| Target criteria not met | 6 | 15% |
| **Total** | **39** | **100%** |

## Length of FSP Partnership for: 3385FA

| Adult Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| >= 1 Year and < 2 Years | 3 | 3 | 6 | 9.23% |
| >= 2 Years and <3 Years | 2 | 1 | 3 | 4.62% |
| >= 3 Years and < 4 Years | 1 | 0 | 1 | 1.54% |
| >= 90 days and < 1 Year | 23 | 12 | 35 | 53.85% |
| Under 90 days | 16 | 4 | 20 | 30.77% |
| **Total Consumer Enrollments** | **45** | **20** | **65** | |

## FSP Adult demographics and Outcomes for: 3352FA
## Served by this reporting unit: 4 Enrollment: 4

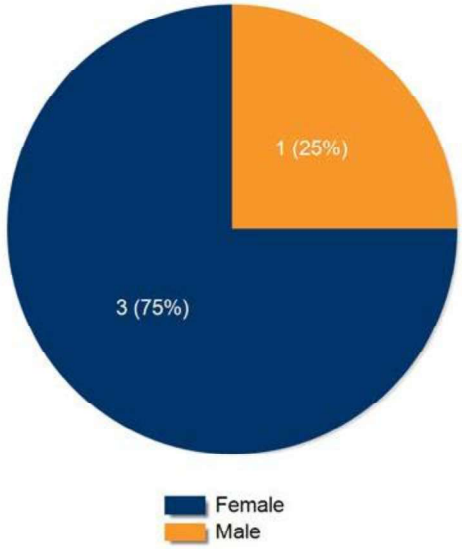
### Demographics

25% of consumers were male and 75% were female.

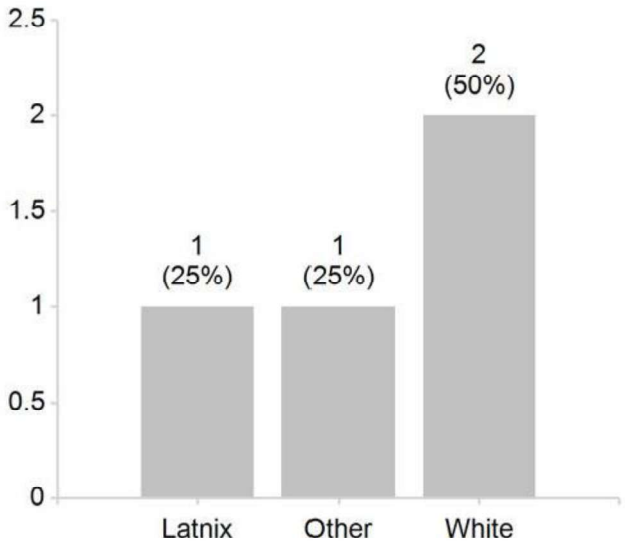
50% of consumers were White, 0% of consumers were Hispanic/Latinx and 0% of consumers were Black/African American.

75% of consumers were 40 to 49 years old.

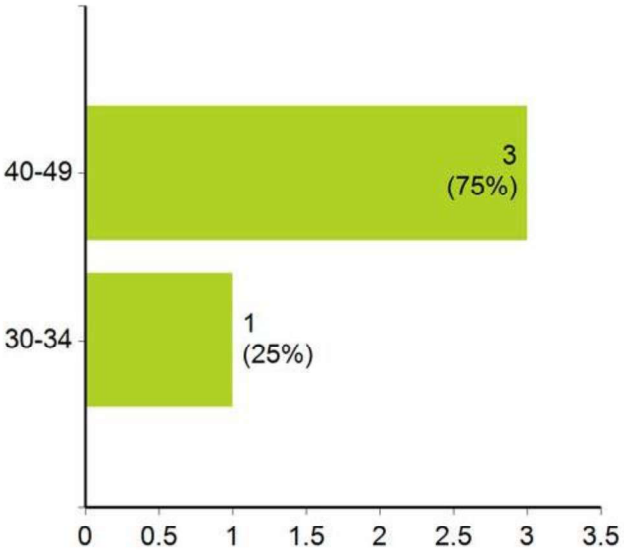
**Gender**



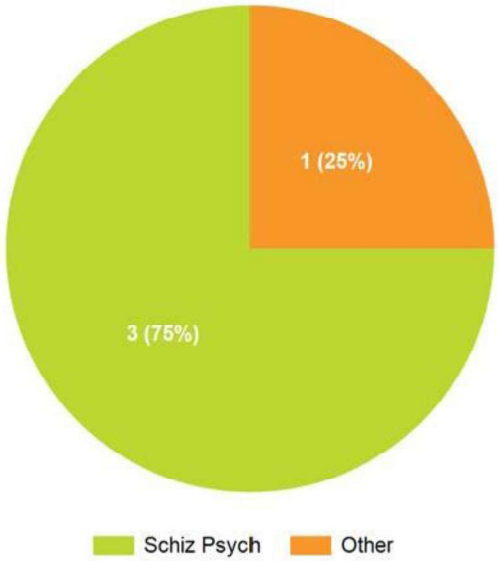

**Race/Ethnicity**




**Age**




**Diagnosis**



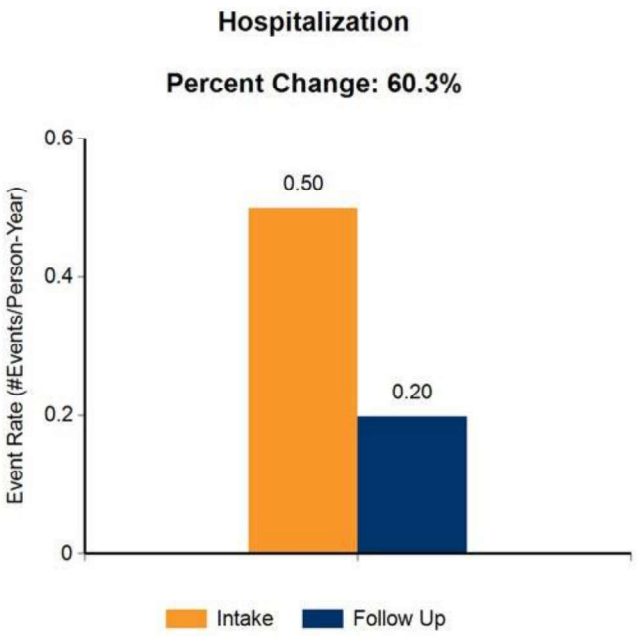
## Service Detail: 3352FA

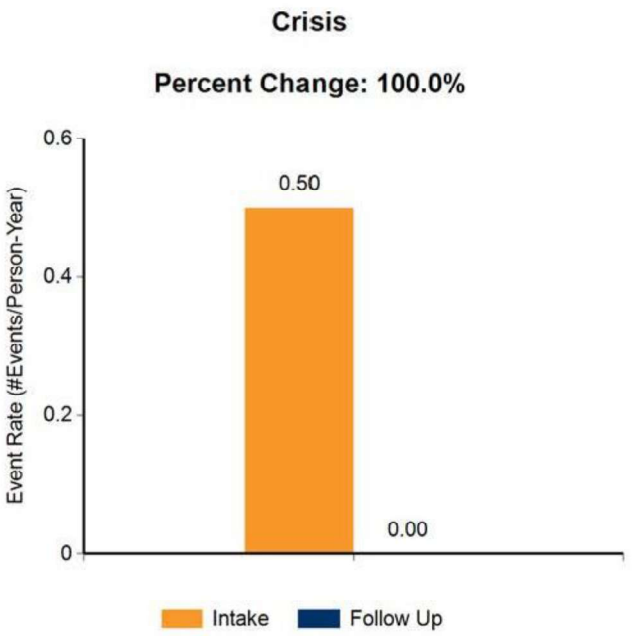
| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Feb | Mar | Apr | May |
|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 1 (100%) | 2 (100%) | 1 (100%) | 1 (100%) | 2 (100%) | 0 (0%) | 0 (0%) | 1 (100%) | 1 (100%) |
| 2-3 | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (100%) | 0 (0%) | 0 (0%) | 0 (0%) |
| 4-7 | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (100%) | 0 (0%) | 0 (0%) |
| Monthly Total | 1 | 2 | 1 | 1 | 2 | 1 | 1 | 1 | 1 |

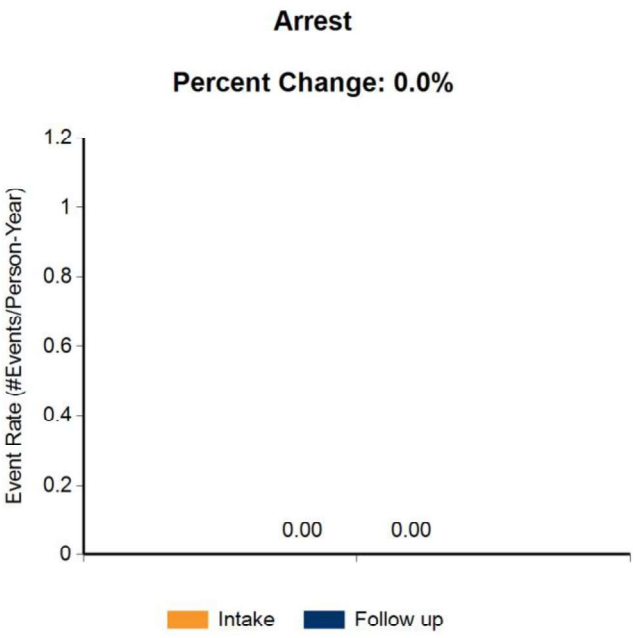
| Type of Service | # of Adult | % of Adult | # of Svcs | Avg. # Svcs |
|---|---|---|---|---|
| Individual Therapy | 1 | 20% | 2 | 2.00 |
| Medication Therapeutic Services | 4 | 80% | 13 | 3.25 |

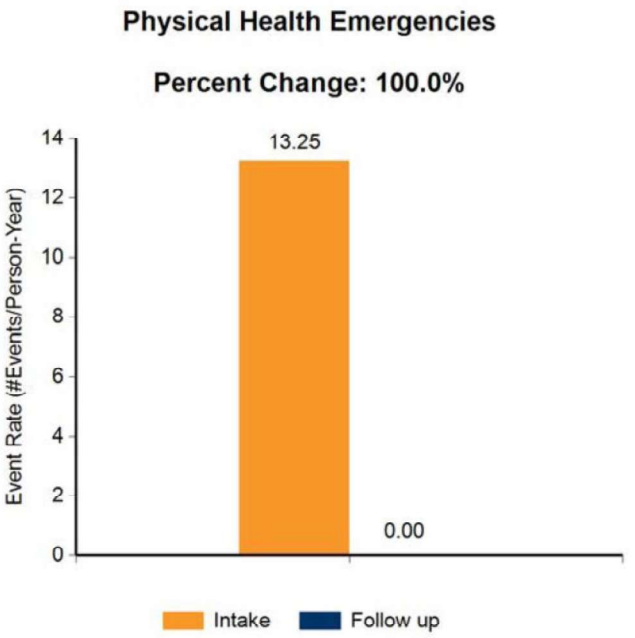
## Outcomes for 3352FA

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

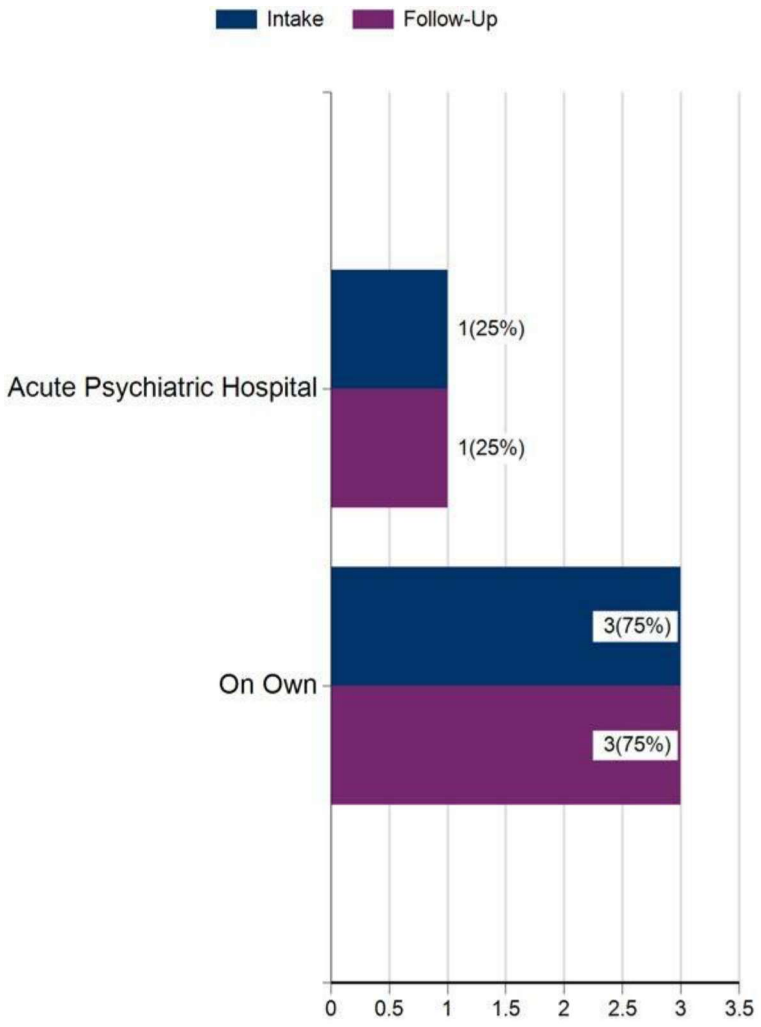


## Outcomes: Residential & Discontinuance (3352FA)

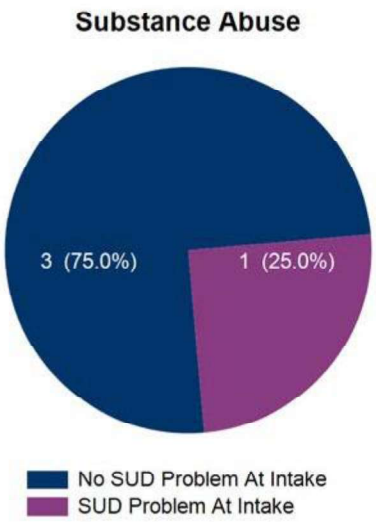


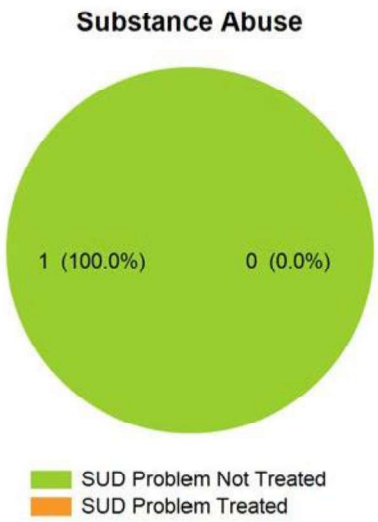

| Discontinuation Reason | Count | % |
|---|---|---|
| Target criteria not met | 2 | 100% |
| Total | 2 | 100% |

## Length of FSP Partnership for: 3352FA

| Adult Time in Partnership | Open | All Consumers | % of Total |
|---|---|---|---|
| >= 3 Years and < 4 Years | 3 | 3 | 75.00% |
| >= 90 days and < 1 Year | 1 | 1 | 25.00% |
| Total Consumer Enrollments | 4 | 4 | |

## Outcomes: Substance Use (3352FA)

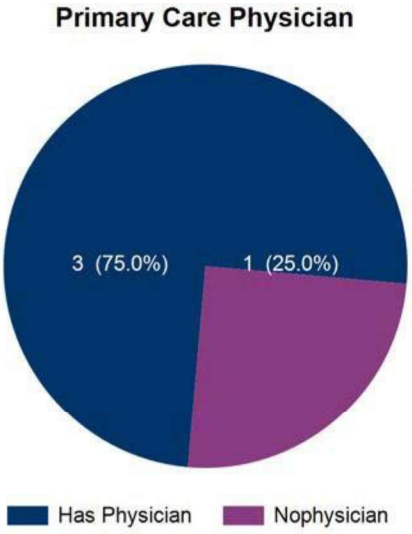



Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (25.0%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 0.0% (0) of the 1 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 0 consumers not identified at intake were noted to have an SU problem on follow-up and 0.0% of them were reported to be in SU services on follow-up.

## Outcomes: Primary Care Physician (3352FA)




Intake: Most adults (25.0%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 1 consumers that did not have a PCP at intake, 1 (100.0%) obtained a PCP while in the program.

# FSP Adult demographics and Outcomes for: 3377FA
## Served by this reporting unit: 284 Enrollment: 291

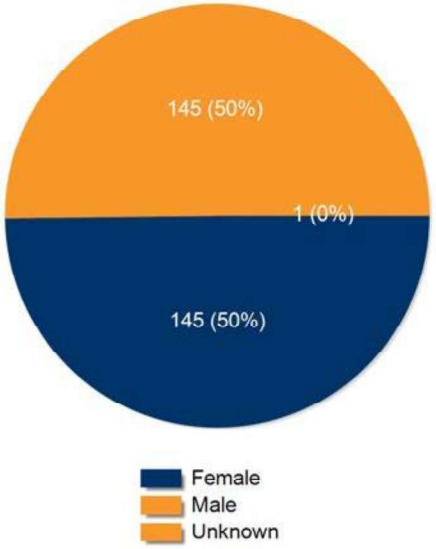
## Demographics

50% of consumers were male and 50% were female.

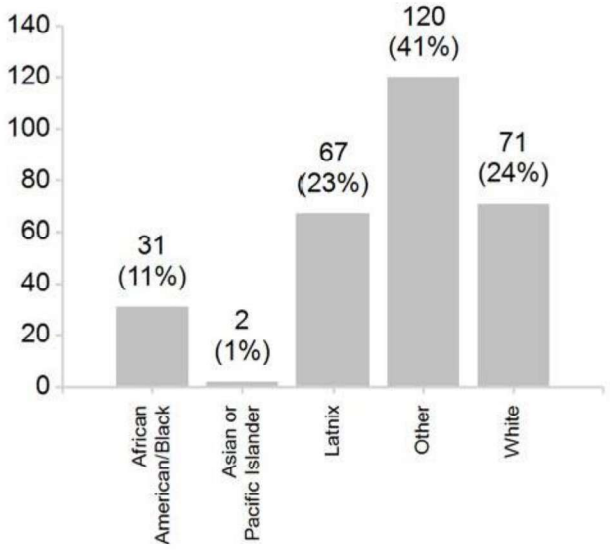
24% of consumers were White, 0% of consumers were Hispanic/Latinx and 11% of consumers were Black/African American.

25% of consumers were 40 to 49 years old.

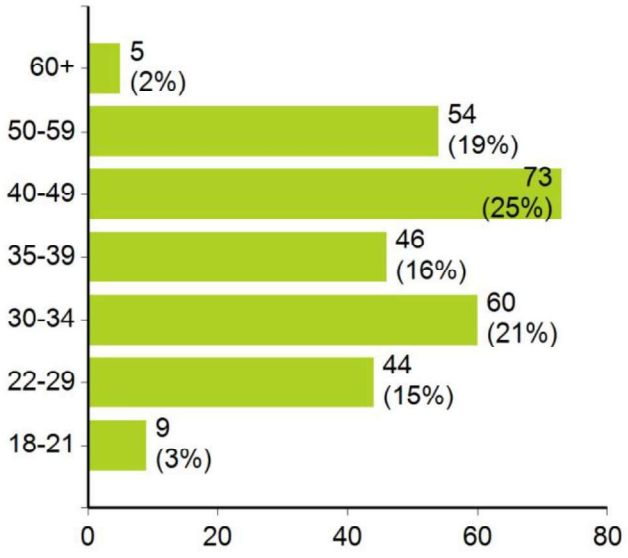
### Gender



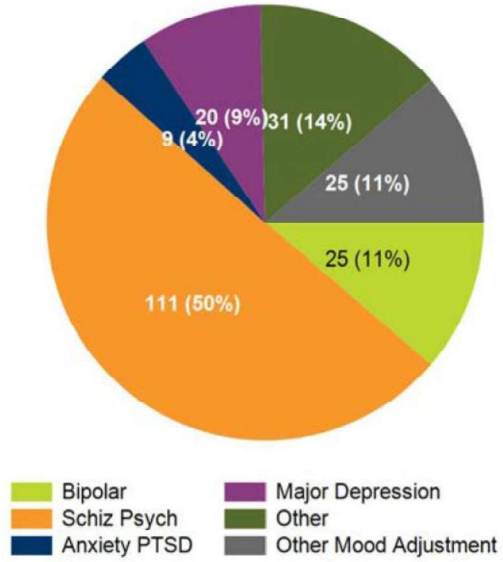

### Race/Ethnicity




### Age




### Diagnosis



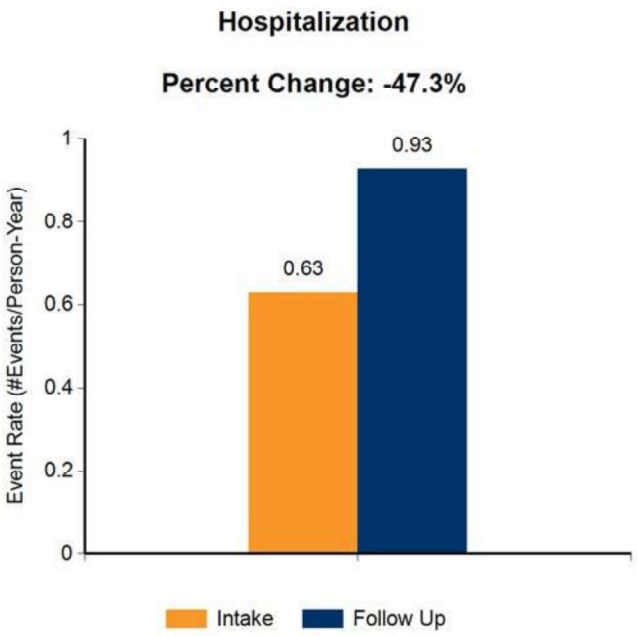
## Service Detail: 3377FA

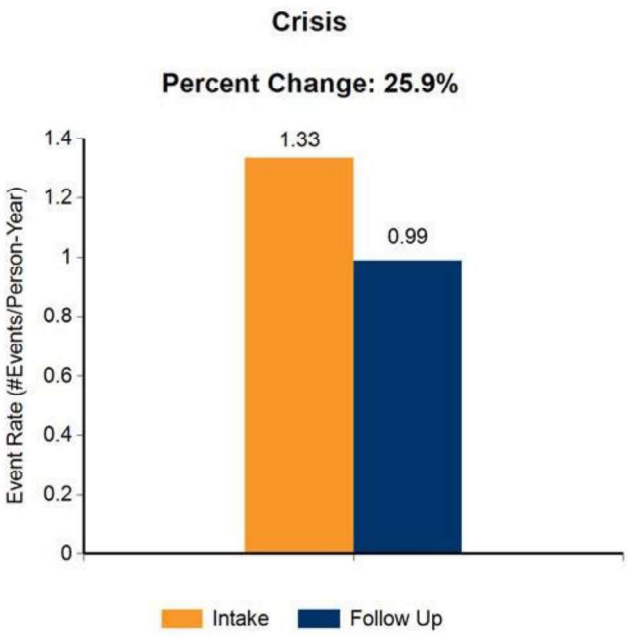
| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 39 (31%) | 26 (20%) | 32 (26%) | 41 (38%) | 38 (38%) | 51 (37%) | 43 (32%) | 30 (31%) | 50 (33%) | 41 (26%) | 25 (18%) | 35 (27%) |
| 2-3 | 35 (28%) | 34 (26%) | 36 (29%) | 22 (20%) | 27 (27%) | 54 (39%) | 46 (35%) | 33 (34%) | 47 (31%) | 46 (29%) | 45 (33%) | 44 (34%) |
| 4-7 | 29 (23%) | 39 (30%) | 30 (24%) | 27 (25%) | 24 (24%) | 23 (17%) | 27 (20%) | 15 (16%) | 28 (18%) | 42 (27%) | 39 (29%) | 26 (20%) |
| 8-13 | 15 (12%) | 19 (15%) | 22 (18%) | 16 (15%) | 12 (12%) | 9 (7%) | 12 (9%) | 13 (14%) | 18 (12%) | 14 (9%) | 15 (11%) | 13 (10%) |
| 14-19 | 3 (2%) | 7 (5%) | 3 (2%) | 1 (1%) | 0 (0%) | 0 (0%) | 3 (2%) | 3 (3%) | 7 (5%) | 12 (8%) | 10 (7%) | 9 (7%) |
| 20-25 | 2 (2%) | 1 (1%) | 0 (0%) | 2 (2%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (1%) | 1 (1%) | 2 (1%) | 1 (1%) | 0 (0%) |
| 26-31 | 0 (0%) | 4 (3%) | 1 (1%) | 0 (0%) | 0 (0%) | 0 (0%) | 2 (2%) | 1 (1%) | 1 (1%) | 0 (0%) | 1 (1%) | 1 (1%) |
| 32+ | 1 (1%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (1%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| Monthly Total | 124 | 130 | 124 | 109 | 101 | 138 | 133 | 96 | 152 | 157 | 136 | 128 |

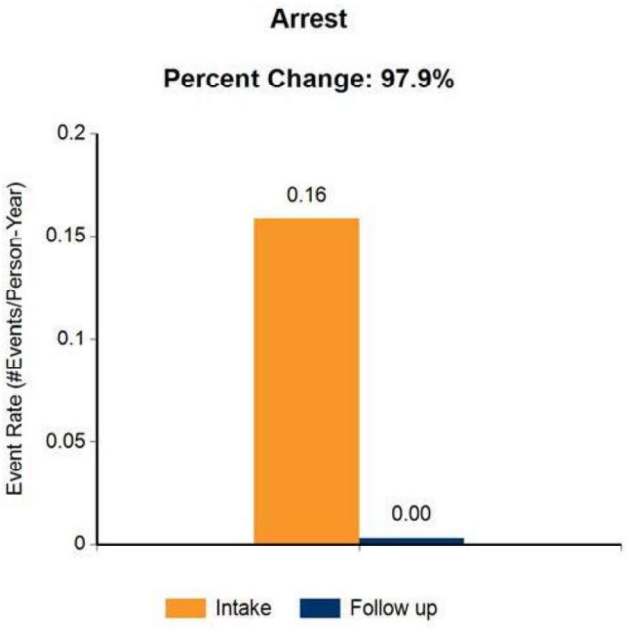
| Type of Service | # of Adult | % of Adult | # of Svcs | Avg. # Svcs |
|---|---|---|---|---|
| Assessment Services | 20 | 2% | 20 | 1.00 |
| Case Management | 273 | 32% | 3,101 | 11.36 |
| Client Supportive Services | 1 | 0% | 1 | 1.00 |
| Crisis | 4 | 0% | 6 | 1.50 |
| Family Therapy | 1 | 0% | 1 | 1.00 |
| Individual Therapy | 27 | 3% | 160 | 5.93 |
| Medication MD Services | 78 | 9% | 170 | 2.18 |
| Medication Therapeutic Services | 70 | 8% | 527 | 7.53 |
| Mental Health Services-Group | 13 | 2% | 44 | 3.38 |
| Mental Health Services-Individual | 226 | 27% | 2,215 | 9.80 |
| Non Face to Face MD | 43 | 5% | 78 | 1.81 |
| Peer MH Education Groups | 2 | 0% | 2 | 1.00 |
| Peer MH Engagement | 14 | 2% | 22 | 1.57 |
| Peer MH Therapeutic Activity | 54 | 6% | 239 | 4.43 |
| Psychiatric Assessment | 18 | 2% | 18 | 1.00 |

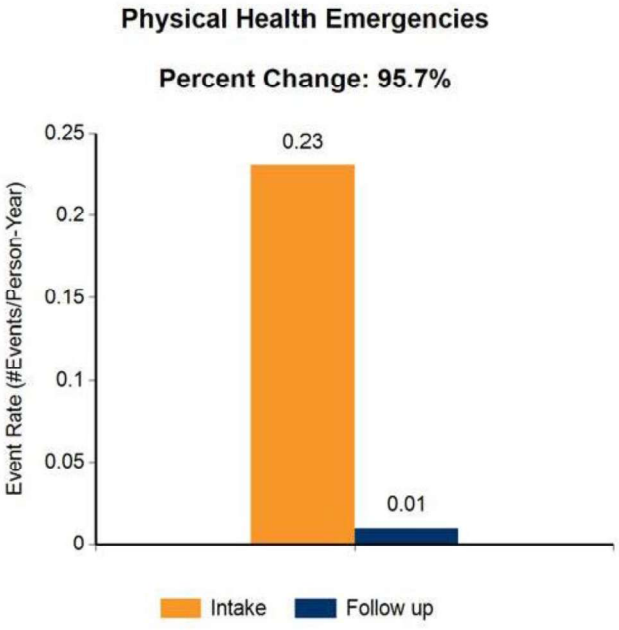
## Outcomes for 3377FA

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

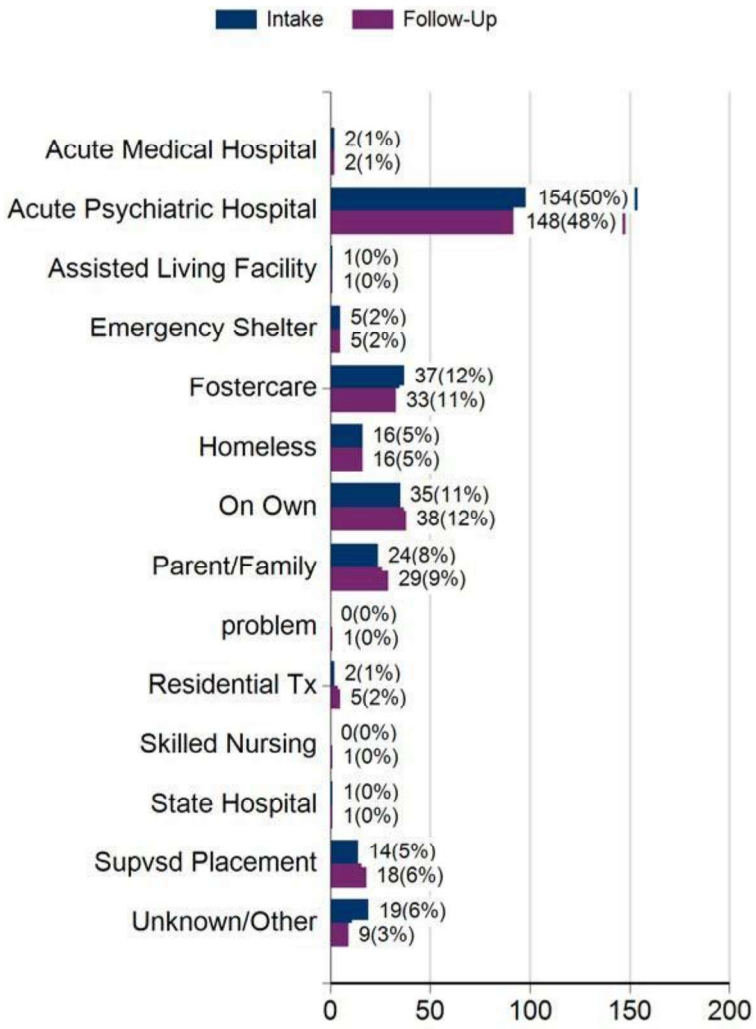


## Outcomes: Residential & Discontinuance (3377FA)

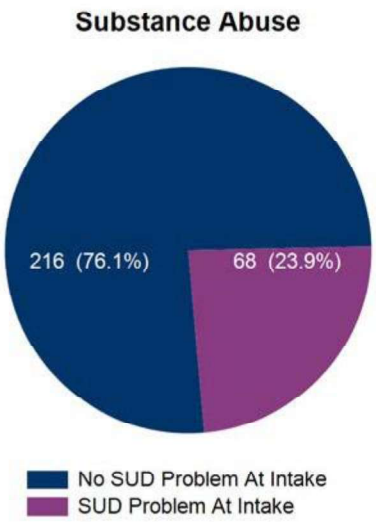


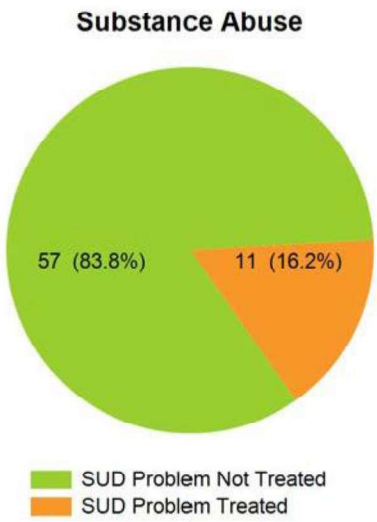

| Discontinuation Reason | Count | % |
|---|---|---|
| Deceased | 2 | 3% |
| Met goals | 3 | 4% |
| Moved out of county/area | 9 | 13% |
| Needs residential care | 1 | 1% |
| Partner cannot be located | 48 | 72% |
| Partner left program | 4 | 6% |
| **Total** | **67** | **100%** |

## Length of FSP Partnership for: 3377FA

| Adult Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| >= 1 Year and < 2 Years | 17 | 44 | 61 | 20.96% |
| >= 2 Years and <3 Years | 6 | 7 | 13 | 4.47% |
| >= 3 Years and < 4 Years | 1 | 4 | 5 | 1.72% |
| >= 4 Years and < 5 years | 2 | 17 | 19 | 6.53% |
| >= 90 days and < 1 Year | 81 | 69 | 150 | 51.55% |
| Under 90 days | 18 | 25 | 43 | 14.78% |
| **Total Consumer Enrollments** | **125** | **166** | **291** | |

## Outcomes: Substance Use (3377FA)

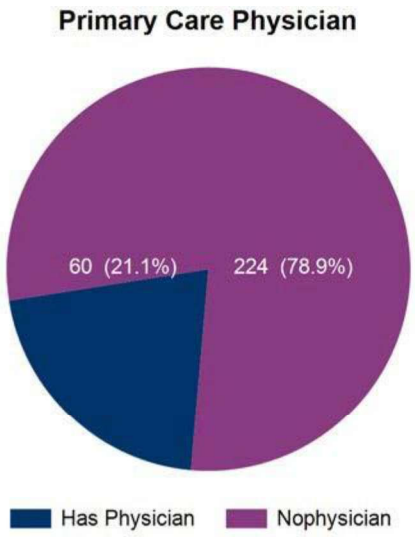



Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (23.9%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 7.0% (4) of the 57 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 21 consumers not identified at intake were noted to have an SU problem on follow-up and 7.0% of them were reported to be in SU services on follow-up.

## Outcomes: Primary Care Physician (3377FA)




Intake: Most adults (78.9%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 224 consumers that did not have a PCP at intake, 31 (14.0%) obtained a PCP while in the program.

## FSP Adult demographics and Outcomes for: 3383FA
## Served by this reporting unit: 73 Enrollment: 75

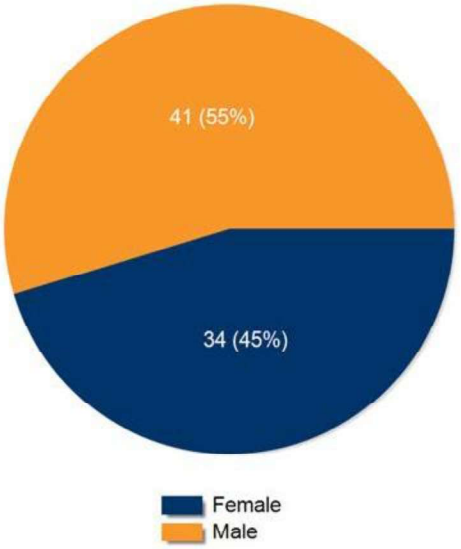
### Demographics

55% of consumers were male and 45% were female.

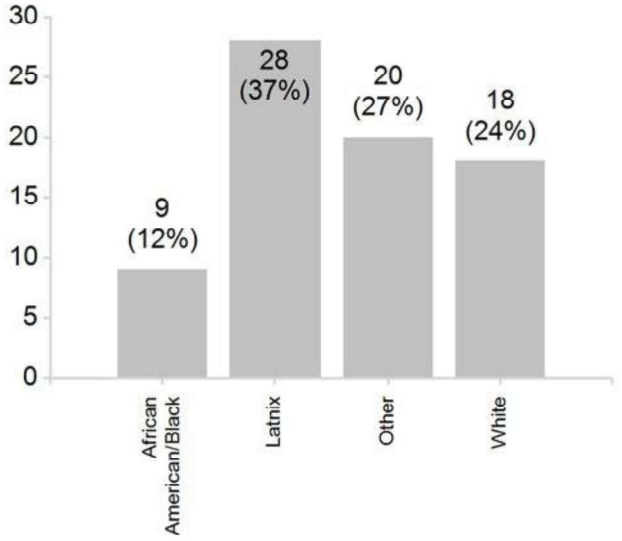
24% of consumers were White, 0% of consumers were Hispanic/Latinx and 12% of consumers were Black/African American.

21% of consumers were 40 to 49 years old.

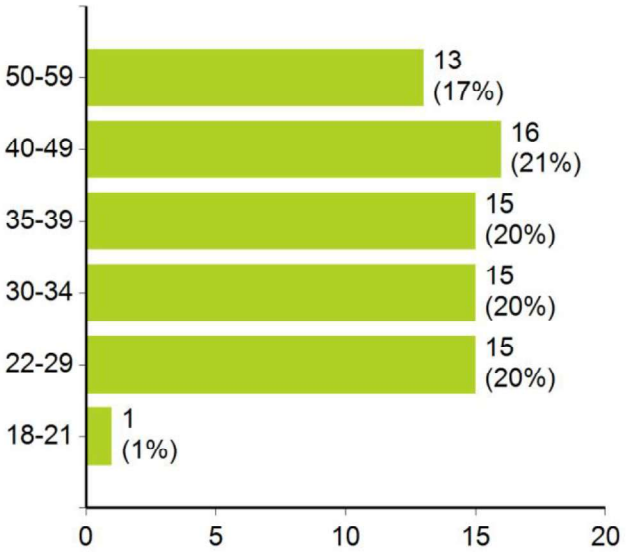
**Gender**



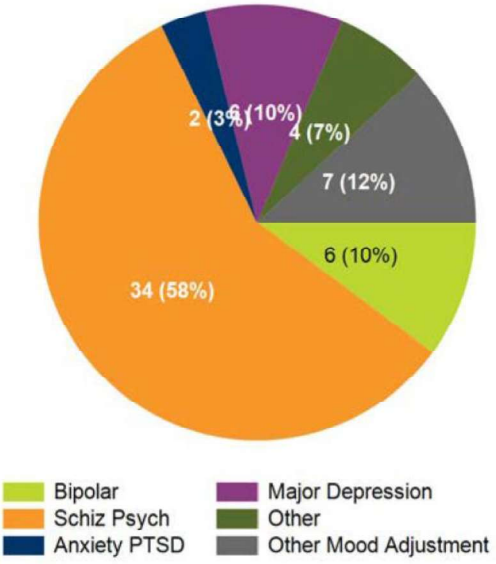

**Race/Ethnicity**




**Age**




**Diagnosis**



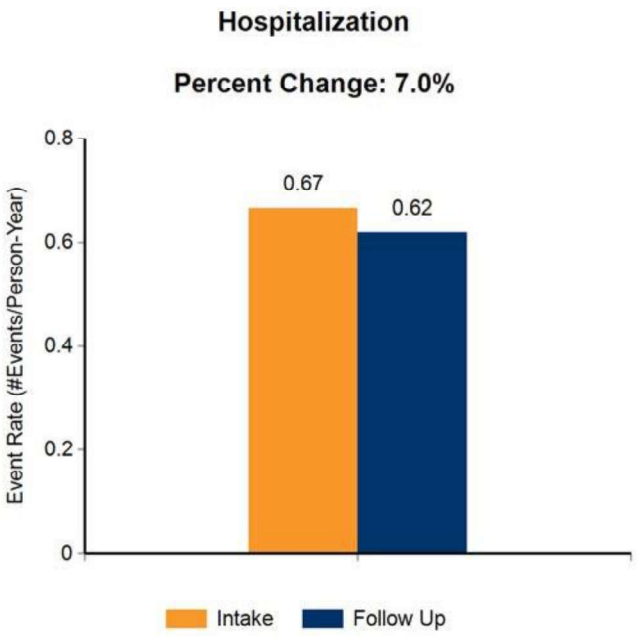
## Service Detail: 3383FA

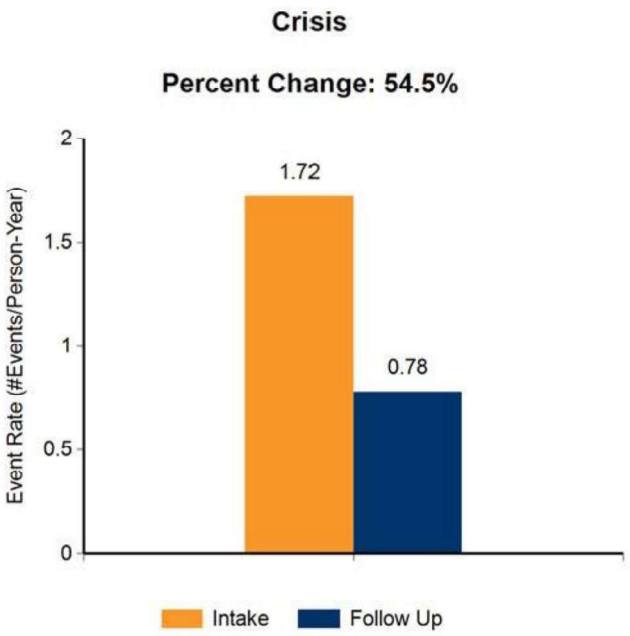
| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 13 (33%) | 9 (22%) | 5 (15%) | 11 (28%) | 13 (39%) | 14 (47%) | 14 (33%) | 8 (27%) | 9 (23%) | 13 (35%) | 6 (20%) | 7 (23%) |
| 2-3 | 18 (45%) | 14 (34%) | 11 (32%) | 13 (33%) | 7 (21%) | 5 (17%) | 12 (29%) | 7 (23%) | 14 (36%) | 7 (19%) | 7 (23%) | 4 (13%) |
| 4-7 | 8 (20%) | 13 (32%) | 11 (32%) | 7 (18%) | 7 (21%) | 5 (17%) | 8 (19%) | 12 (40%) | 8 (21%) | 12 (32%) | 9 (30%) | 13 (42%) |
| 8-13 | 1 (3%) | 4 (10%) | 6 (18%) | 7 (18%) | 4 (12%) | 6 (20%) | 6 (14%) | 3 (10%) | 6 (15%) | 2 (5%) | 8 (27%) | 5 (16%) |
| 14-19 | 0 (0%) | 1 (2%) | 1 (3%) | 2 (5%) | 2 (6%) | 0 (0%) | 1 (2%) | 0 (0%) | 1 (3%) | 3 (8%) | 0 (0%) | 2 (6%) |
| 20-25 | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (2%) | 0 (0%) | 1 (3%) | 0 (0%) | 0 (0%) | 0 (0%) |
| Monthly Total | 40 | 41 | 34 | 40 | 33 | 30 | 42 | 30 | 39 | 37 | 30 | 31 |

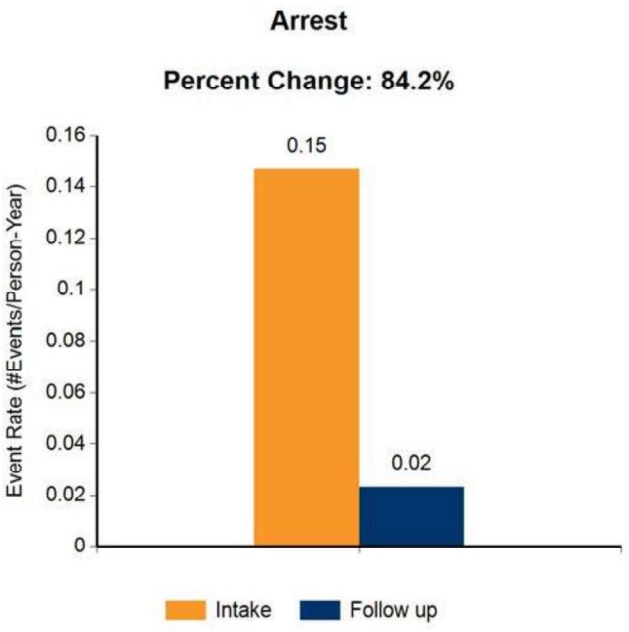
| Type of Service | # of Adult | % of Adult | # of Svcs | Avg. # Svcs |
|---|---|---|---|---|
| Assessment Services | 4 | 2% | 4 | 1.00 |
| Case Management | 43 | 21% | 851 | 19.79 |
| Client Supportive Services | 1 | 0% | 1 | 1.00 |
| Crisis | 2 | 1% | 2 | 1.00 |
| Individual Therapy | 2 | 1% | 8 | 4.00 |
| Medication MD Services | 47 | 22% | 206 | 4.38 |
| Medication Therapeutic Services | 23 | 11% | 94 | 4.09 |
| Mental Health Services-Group | 1 | 0% | 1 | 1.00 |
| Mental Health Services-Individual | 49 | 23% | 483 | 9.86 |
| Non Face to Face MD | 31 | 15% | 92 | 2.97 |
| Psychiatric Assessment | 6 | 3% | 6 | 1.00 |

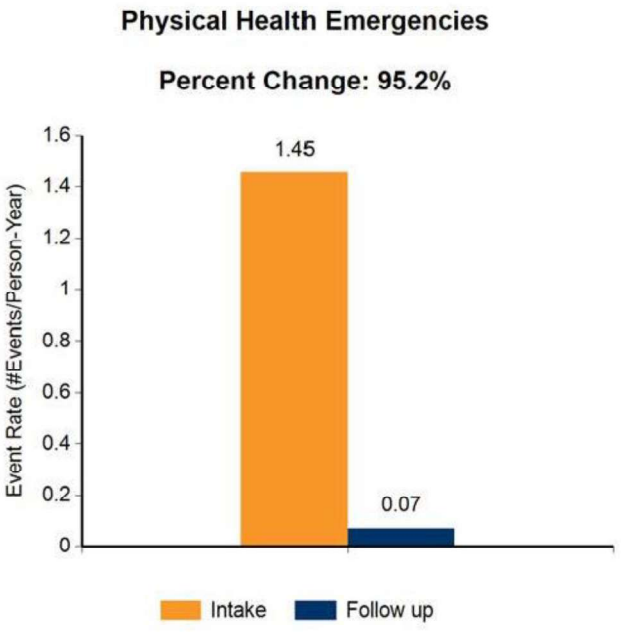
## Outcomes for 3383FA

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

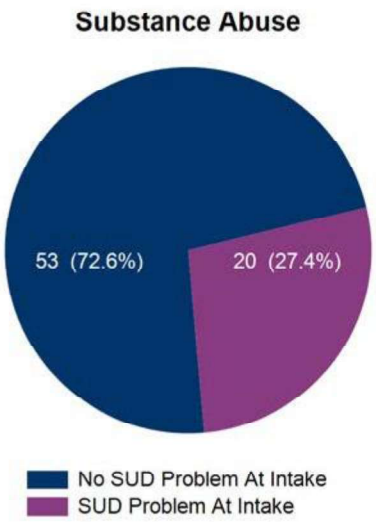


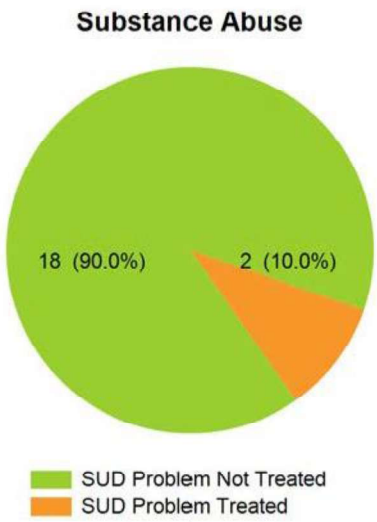



## Outcomes: Substance Use (3383FA)

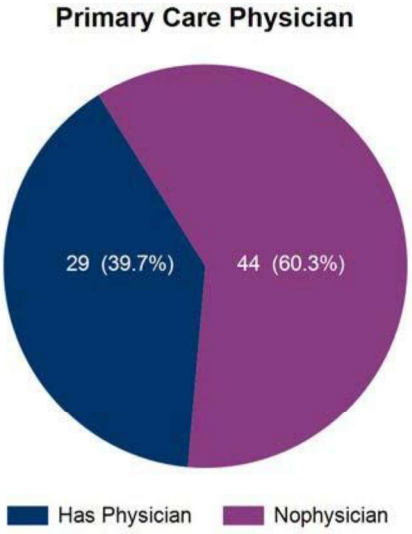



Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (27.4%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 27.8% (5) of the 18 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 11 consumers not identified at intake were noted to have an SU problem on follow-up and 28.0% of them were reported to be in SU services on follow-up.

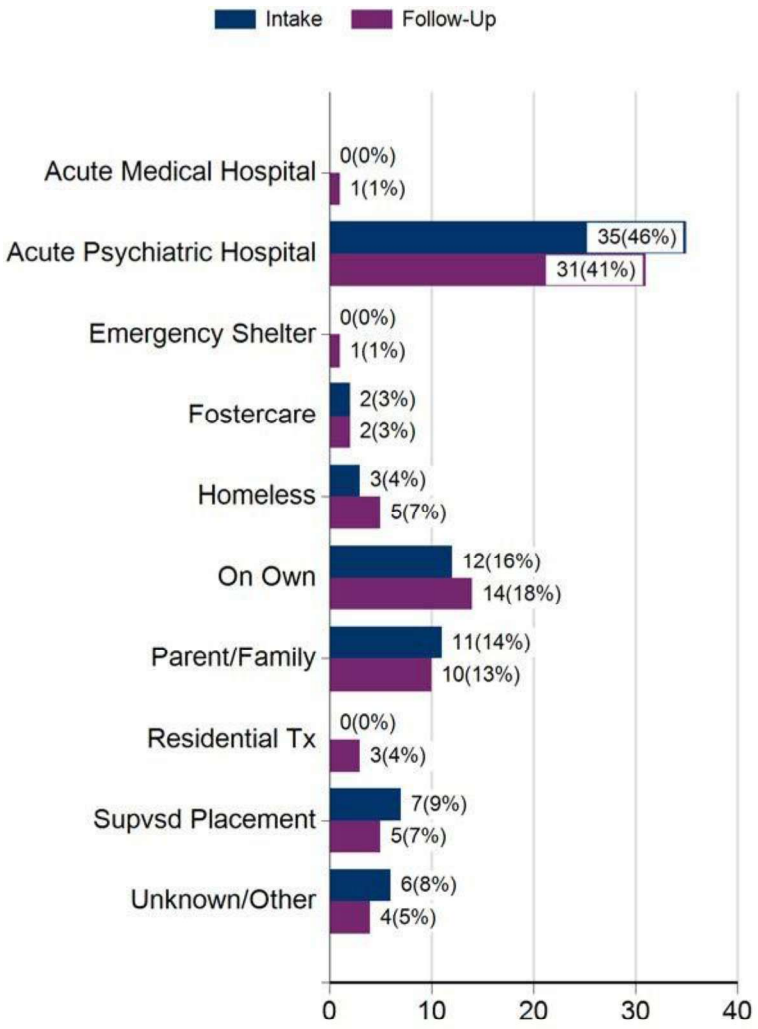
## Outcomes: Primary Care Physician (3383FA)




Intake: Most adults (60.3%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 44 consumers that did not have a PCP at intake, 12 (27.0%) obtained a PCP while in the program.

## Outcomes: Residential & Discontinuance (3383FA)




| Discontinuation Reason | Count | % |
|---|---|---|
| Justice system | 1 | 13% |
| Moved out of county/area | 3 | 38% |
| Other | 1 | 13% |
| Partner cannot be located | 3 | 38% |
| Total | 8 | 100% |

## Length of FSP Partnership for: 3383FA

| Adult Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| >= 1 Year and < 2 Years | 3 | 12 | 15 | 20.00% |
| >= 2 Years and <3 Years | 3 | 4 | 7 | 9.33% |
| >= 3 Years and < 4 Years | 4 | 9 | 13 | 17.33% |
| >= 4 Years and < 5 years | 2 | 5 | 7 | 9.33% |
| >= 90 days and < 1 Year | 4 | 19 | 23 | 30.67% |
| Under 90 days | 8 | 2 | 10 | 13.33% |
| Total Consumer Enrollments | 24 | 51 | 75 | |

## FSP Adult demographics and Outcomes for: 33MTFA
## Served by this reporting unit: 55 Enrollment: 56

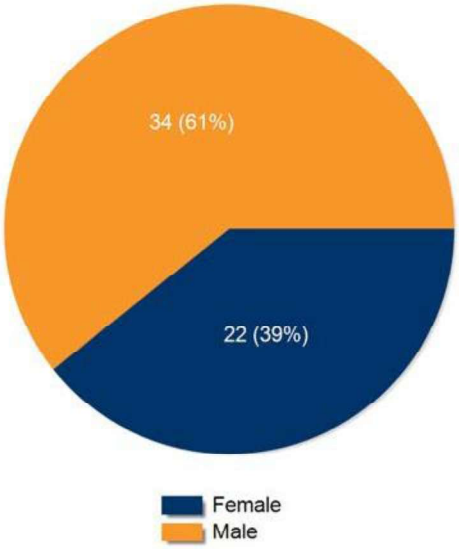
### Demographics

61% of consumers were male and 39% were female.

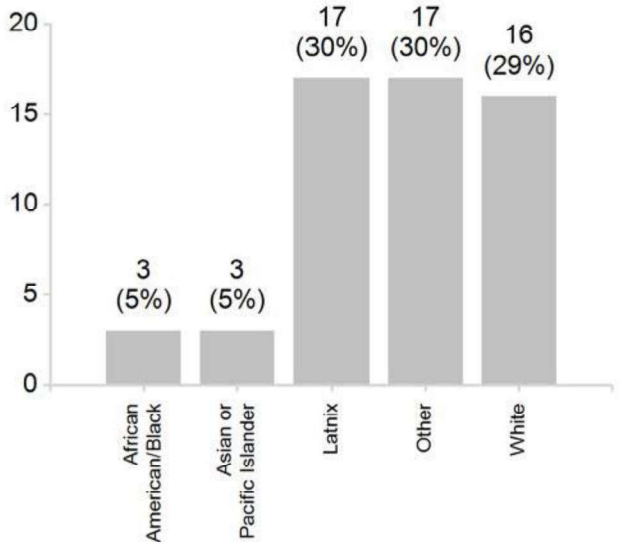
29% of consumers were White, 0% of consumers were Hispanic/Latinx and 5% of consumers were Black/African American.

13% of consumers were 40 to 49 years old.

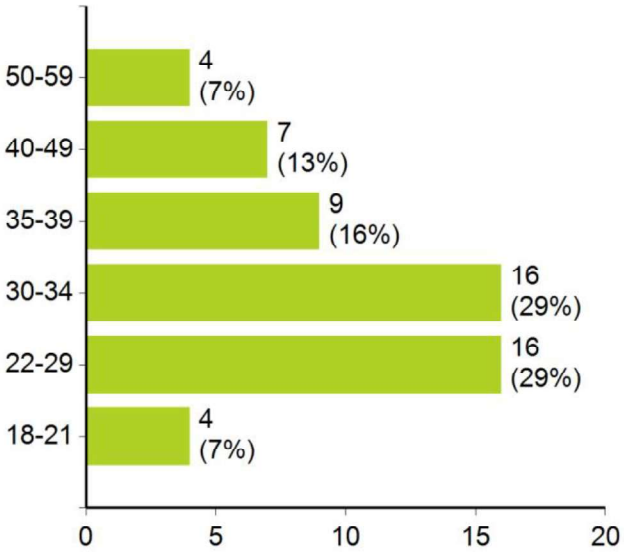
**Gender**



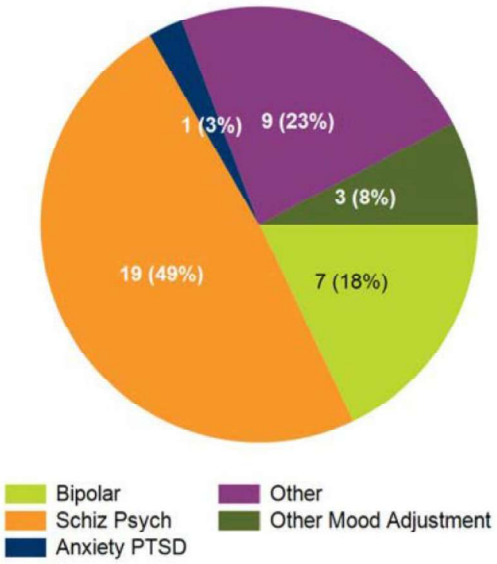

**Race/Ethnicity**




**Age**




**Diagnosis**



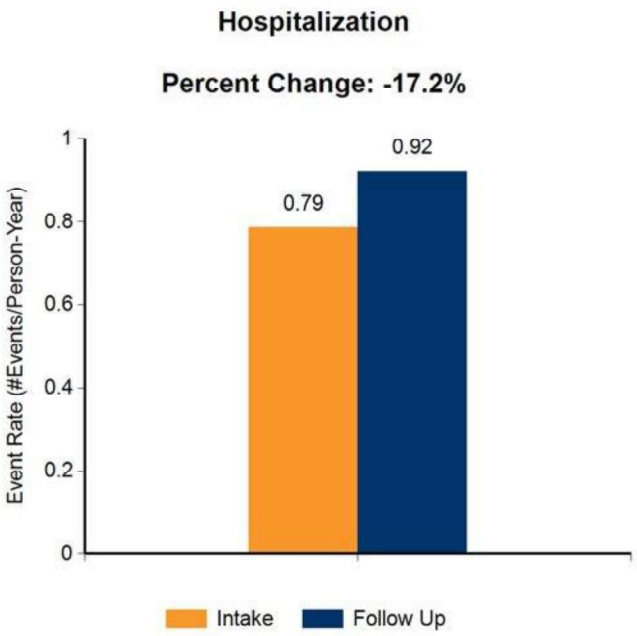
## Service Detail: 33MTFA

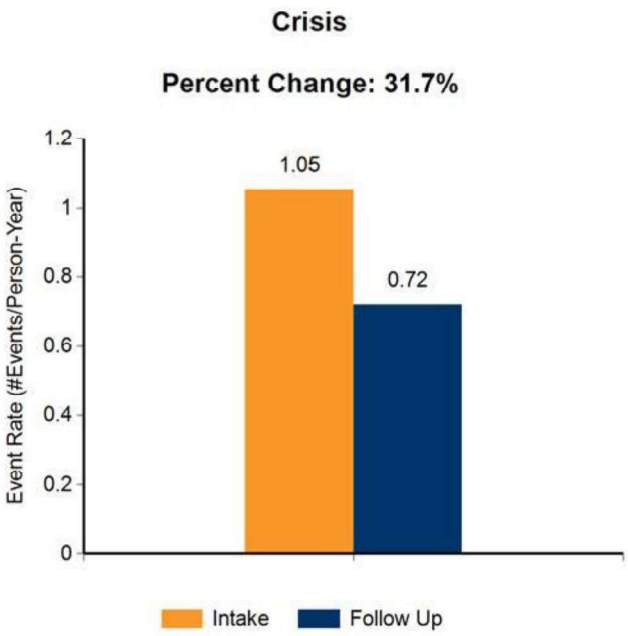
| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 2 (8%) | 3 (14%) | 7 (29%) | 3 (14%) | 2 (9%) | 0 (0%) | 1 (5%) | 2 (9%) | 1 (5%) | 1 (5%) | 3 (14%) | 1 (5%) |
| 2-3 | 6 (25%) | 5 (23%) | 4 (17%) | 2 (9%) | 5 (22%) | 6 (32%) | 4 (19%) | 5 (23%) | 4 (19%) | 4 (20%) | 4 (18%) | 5 (24%) |
| 4-7 | 9 (38%) | 7 (32%) | 8 (33%) | 9 (41%) | 12 (52%) | 4 (21%) | 8 (38%) | 10 (45%) | 6 (29%) | 6 (30%) | 7 (32%) | 6 (29%) |
| 8-13 | 7 (29%) | 2 (9%) | 3 (13%) | 7 (32%) | 4 (17%) | 8 (42%) | 8 (38%) | 4 (18%) | 7 (33%) | 5 (25%) | 4 (18%) | 7 (33%) |
| 14-19 | 0 (0%) | 4 (18%) | 1 (4%) | 0 (0%) | 0 (0%) | 1 (5%) | 0 (0%) | 1 (5%) | 3 (14%) | 3 (15%) | 3 (14%) | 2 (10%) |
| 20-25 | 0 (0%) | 0 (0%) | 0 (0%) | 1 (5%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (5%) | 0 (0%) |
| 26-31 | 0 (0%) | 1 (5%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (5%) | 0 (0%) | 0 (0%) |
| 32+ | 0 (0%) | 0 (0%) | 1 (4%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| Monthly Total | 24 | 22 | 24 | 22 | 23 | 19 | 21 | 22 | 21 | 20 | 22 | 21 |

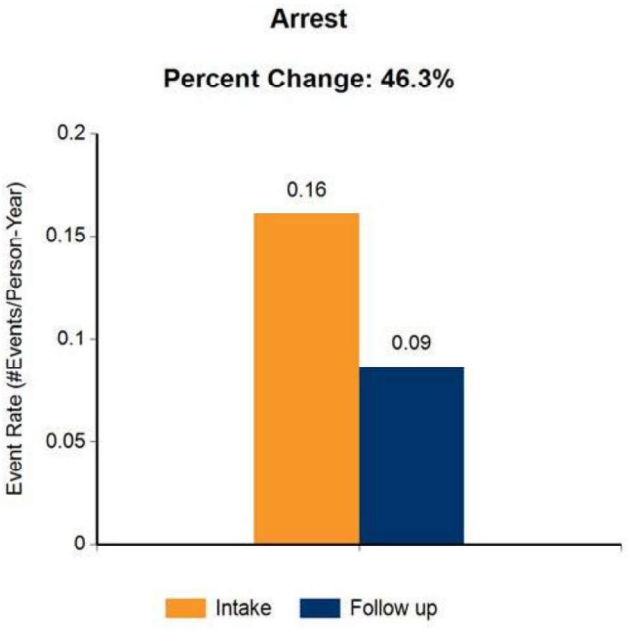
| Type of Service | # of Adult | % of Adult | # of Svcs | Avg. # Svcs |
|---|---|---|---|---|
| Assessment Services | 8 | 3% | 10 | 1.25 |
| Case Management | 43 | 17% | 362 | 8.42 |
| Crisis | 4 | 2% | 6 | 1.50 |
| Family Therapy | 3 | 1% | 7 | 2.33 |
| Individual Therapy | 19 | 7% | 194 | 10.21 |
| Medication MD Services | 37 | 14% | 169 | 4.57 |
| Medication Therapeutic Services | 42 | 16% | 305 | 7.26 |
| Mental Health Services-Group | 6 | 2% | 14 | 2.33 |
| Mental Health Services-Individual | 37 | 14% | 393 | 10.62 |
| Non Face to Face MD | 27 | 10% | 69 | 2.56 |
| Peer MH Education Groups | 1 | 0% | 5 | 5.00 |
| Peer MH Engagement | 4 | 2% | 8 | 2.00 |
| Peer MH Therapeutic Activity | 23 | 9% | 150 | 6.52 |
| Psychiatric Assessment | 6 | 2% | 6 | 1.00 |

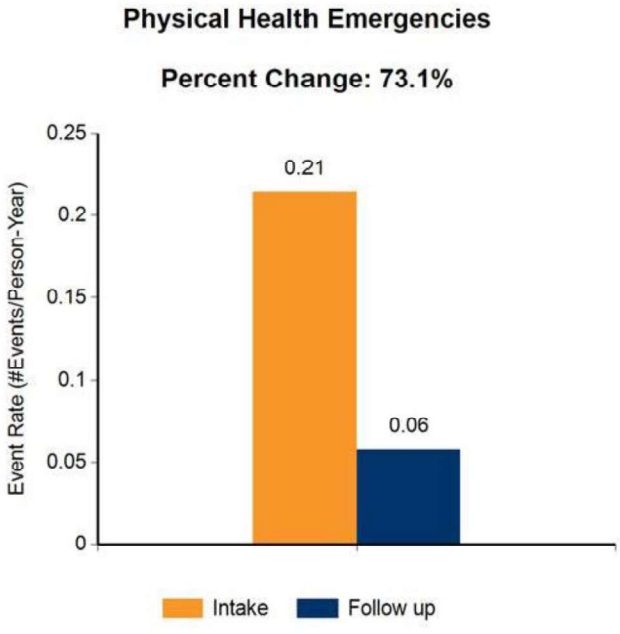
## Outcomes for 33MTFA

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

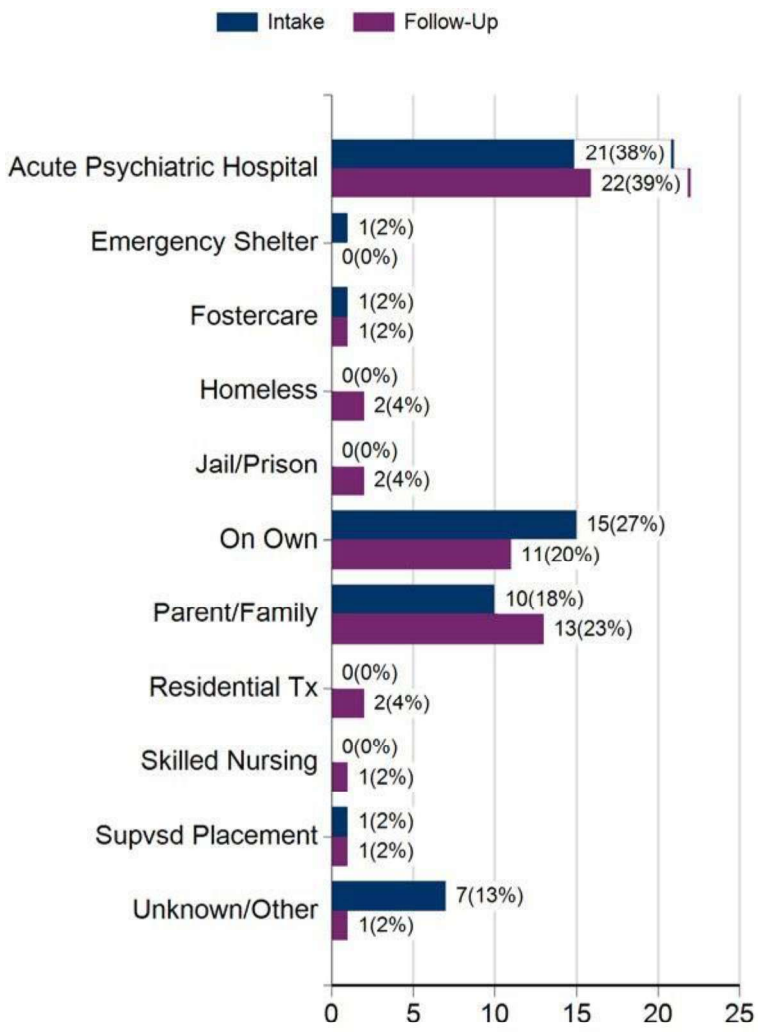


## Outcomes: Residential & Discontinuance (33MTFA)

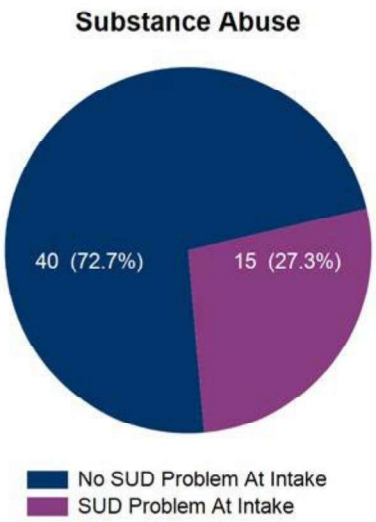


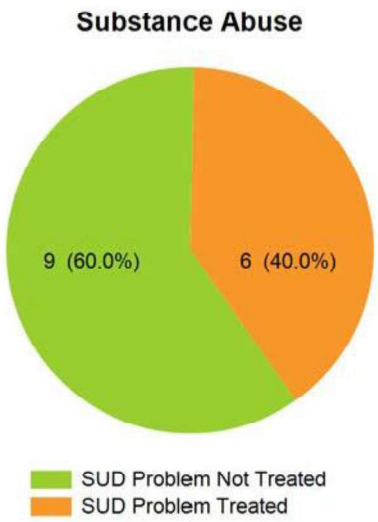

| Discontinuation Reason | Count | % |
|---|---|---|
| Deceased | 1 | 3% |
| Justice system | 4 | 11% |
| Met goals | 3 | 9% |
| Moved out of county/area | 3 | 9% |
| Partner cannot be located | 9 | 26% |
| Partner left program | 11 | 31% |
| Target criteria not met | 4 | 11% |
| **Total** | **35** | **100%** |

## Length of FSP Partnership for: 33MTFA

| Adult Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| >= 1 Year and < 2 Years | 2 | 5 | 7 | 12.50% |
| >= 2 Years and <3 Years | 2 | 2 | 4 | 7.14% |
| >= 90 days and < 1 Year | 17 | 10 | 27 | 48.21% |
| Under 90 days | 15 | 3 | 18 | 32.14% |
| **Total Consumer Enrollments** | **36** | **20** | **56** | |

## Outcomes: Substance Use (33MTFA)

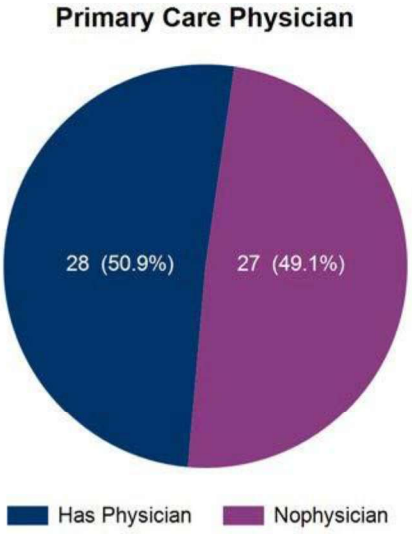



Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (27.3%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 11.1% (1) of the 9 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 7 consumers not identified at intake were noted to have an SU problem on follow-up and 11.0% of them were reported to be in SU services on follow-up.

## Outcomes: Primary Care Physician (33MTFA)




Intake: Most adults (49.1%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 27 consumers that did not have a PCP at intake, 4 (15.0%) obtained a PCP while in the program.

# FSP Adult demographics and Outcomes for: 33MUFA
## Served by this reporting unit: 88 Enrollment: 100

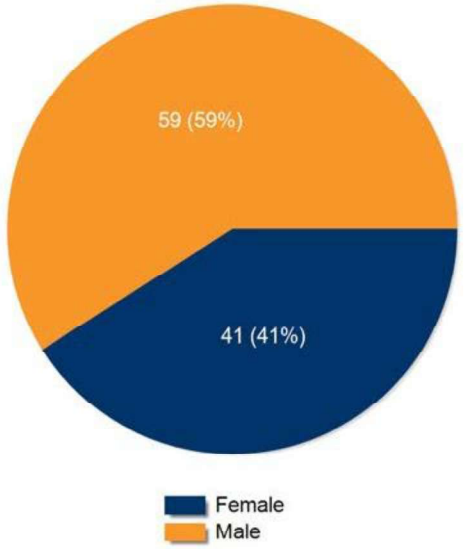
### Demographics

59% of consumers were male and 41% were female.

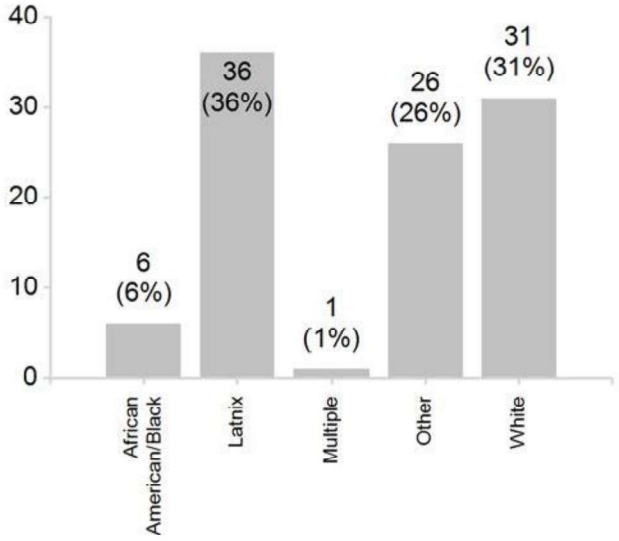
31% of consumers were White, 0% of consumers were Hispanic/Latinx and 6% of consumers were Black/African American.

28% of consumers were 40 to 49 years old.

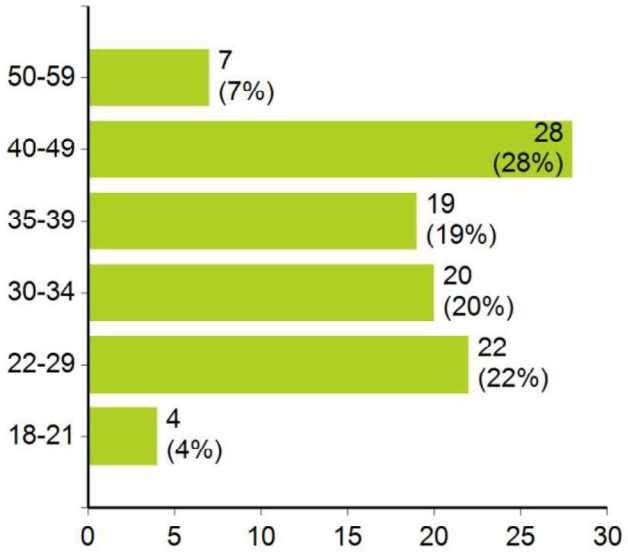
**Gender**



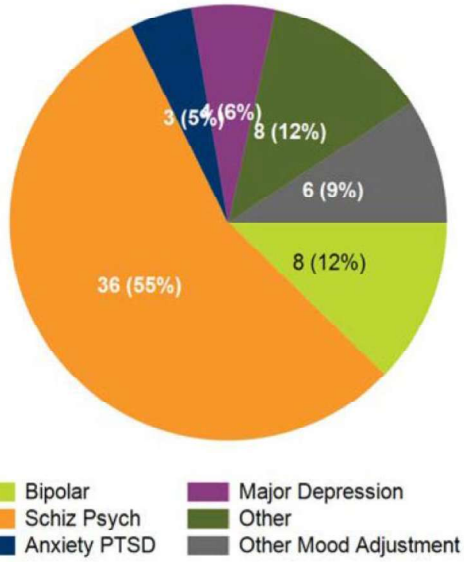

**Race/Ethnicity**




**Age**




**Diagnosis**



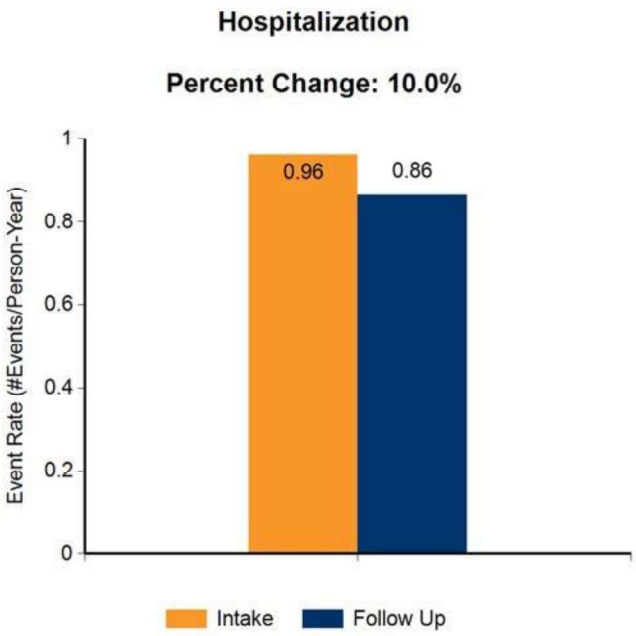
## Service Detail: 33MUFA

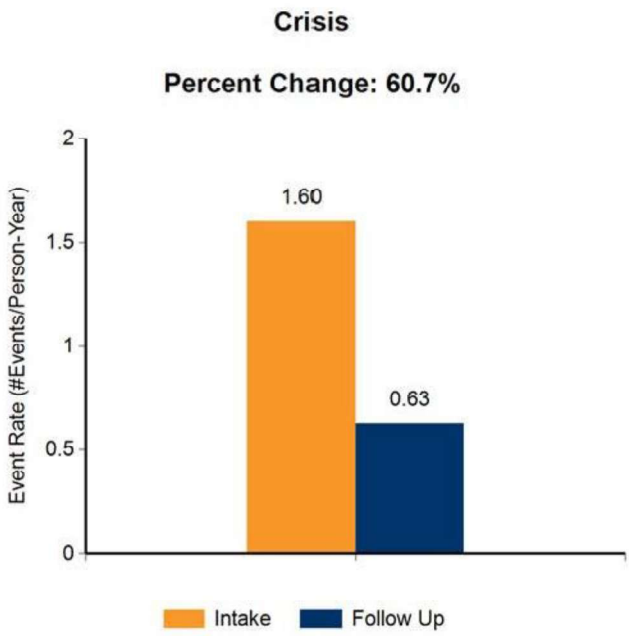
| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 6 (15%) | 2 (5%) | 8 (19%) | 8 (18%) | 7 (16%) | 9 (21%) | 4 (9%) | 5 (14%) | 11 (24%) | 12 (27%) | 4 (11%) | 4 (11%) |
| 2-3 | 7 (18%) | 7 (17%) | 8 (19%) | 10 (23%) | 10 (22%) | 9 (21%) | 13 (30%) | 5 (14%) | 7 (16%) | 3 (7%) | 7 (20%) | 6 (16%) |
| 4-7 | 14 (36%) | 13 (32%) | 17 (40%) | 16 (36%) | 16 (36%) | 15 (36%) | 8 (18%) | 16 (43%) | 12 (27%) | 15 (33%) | 8 (23%) | 8 (22%) |
| 8-13 | 8 (21%) | 14 (34%) | 8 (19%) | 8 (18%) | 8 (18%) | 7 (17%) | 12 (27%) | 7 (19%) | 9 (20%) | 4 (9%) | 7 (20%) | 9 (24%) |
| 14-19 | 2 (5%) | 3 (7%) | 0 (0%) | 1 (2%) | 2 (4%) | 1 (2%) | 5 (11%) | 1 (3%) | 4 (9%) | 7 (16%) | 3 (9%) | 4 (11%) |
| 20-25 | 1 (3%) | 1 (2%) | 0 (0%) | 0 (0%) | 1 (2%) | 0 (0%) | 1 (2%) | 2 (5%) | 1 (2%) | 2 (4%) | 4 (11%) | 4 (11%) |
| 26-31 | 0 (0%) | 0 (0%) | 0 (0%) | 1 (2%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (3%) | 2 (5%) |
| 32+ | 1 (3%) | 1 (2%) | 1 (2%) | 0 (0%) | 1 (2%) | 1 (2%) | 1 (2%) | 1 (3%) | 1 (2%) | 2 (4%) | 1 (3%) | 0 (0%) |
| Monthly Total | 39 | 41 | 42 | 44 | 45 | 42 | 44 | 37 | 45 | 45 | 35 | 37 |

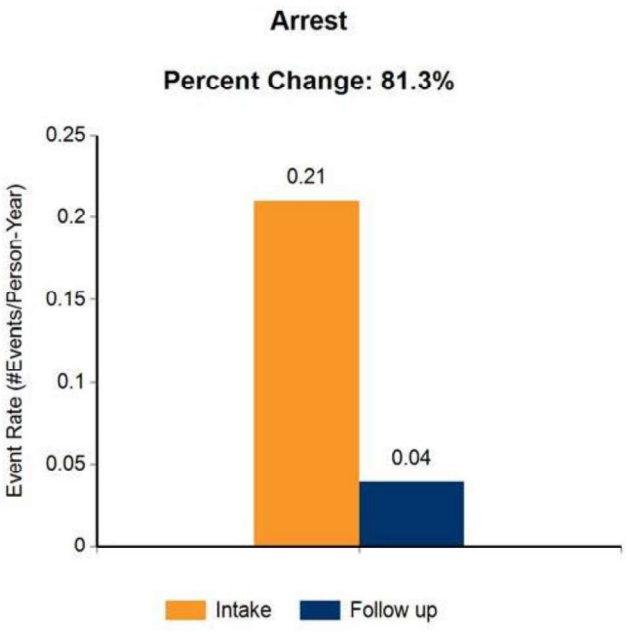
| Type of Service | # of Adult | % of Adult | # of Svcs | Avg. # Svcs |
|---|---|---|---|---|
| Assessment Services | 13 | 3% | 17 | 1.31 |
| Case Management | 69 | 16% | 779 | 11.29 |
| Collateral Services | 1 | 0% | 1 | 1.00 |
| Crisis | 4 | 1% | 7 | 1.75 |
| Family Therapy | 1 | 0% | 1 | 1.00 |
| Individual Therapy | 12 | 3% | 167 | 13.92 |
| Medication MD Services | 49 | 11% | 252 | 5.14 |
| Medication Therapeutic Services | 59 | 14% | 313 | 5.31 |
| Mental Health Services-Group | 17 | 4% | 99 | 5.82 |
| Mental Health Services-Individual | 69 | 16% | 861 | 12.48 |
| Non Face to Face MD | 37 | 9% | 148 | 4.00 |
| Peer MH Education Groups | 6 | 1% | 18 | 3.00 |
| Peer MH Engagement | 14 | 3% | 19 | 1.36 |
| Peer MH Therapeutic Activity | 68 | 16% | 886 | 13.03 |
| Psychiatric Assessment | 13 | 3% | 14 | 1.08 |

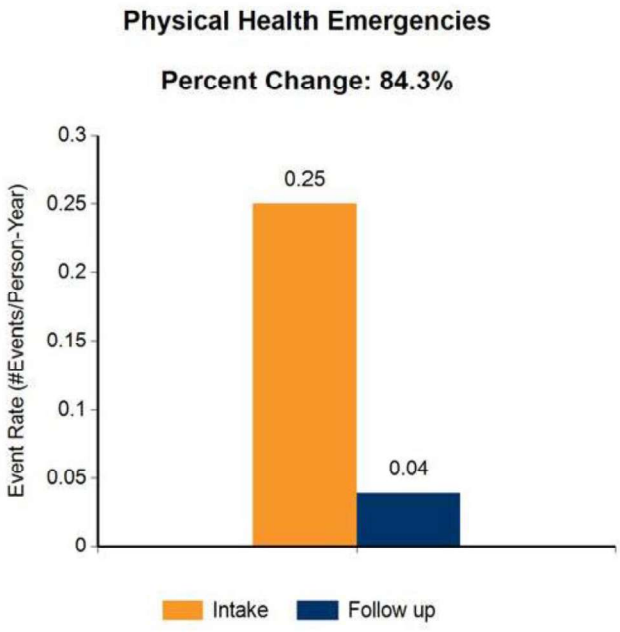
## Outcomes for 33MUFA

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

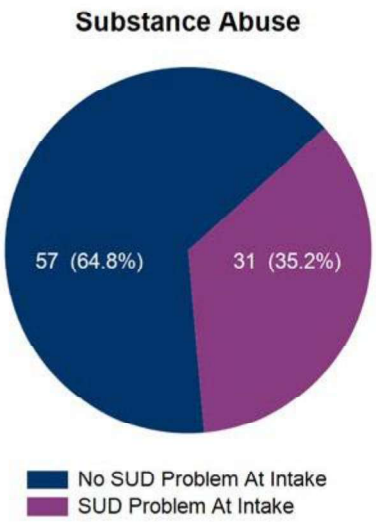


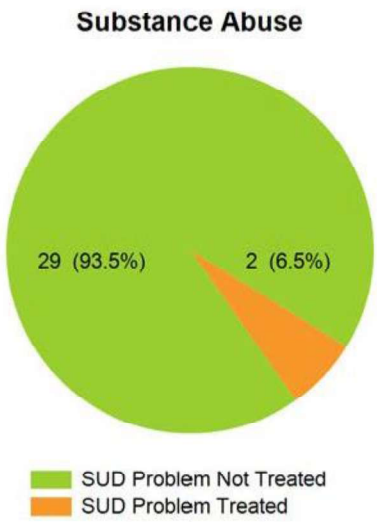



## Outcomes: Substance Use (33MUFA)

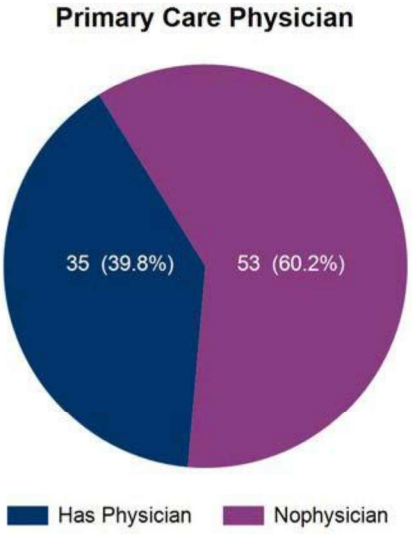



Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (35.2%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 13.8% (4) of the 29 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 17 consumers not identified at intake were noted to have an SU problem on follow-up and 14.0% of them were reported to be in SU services on follow-up.

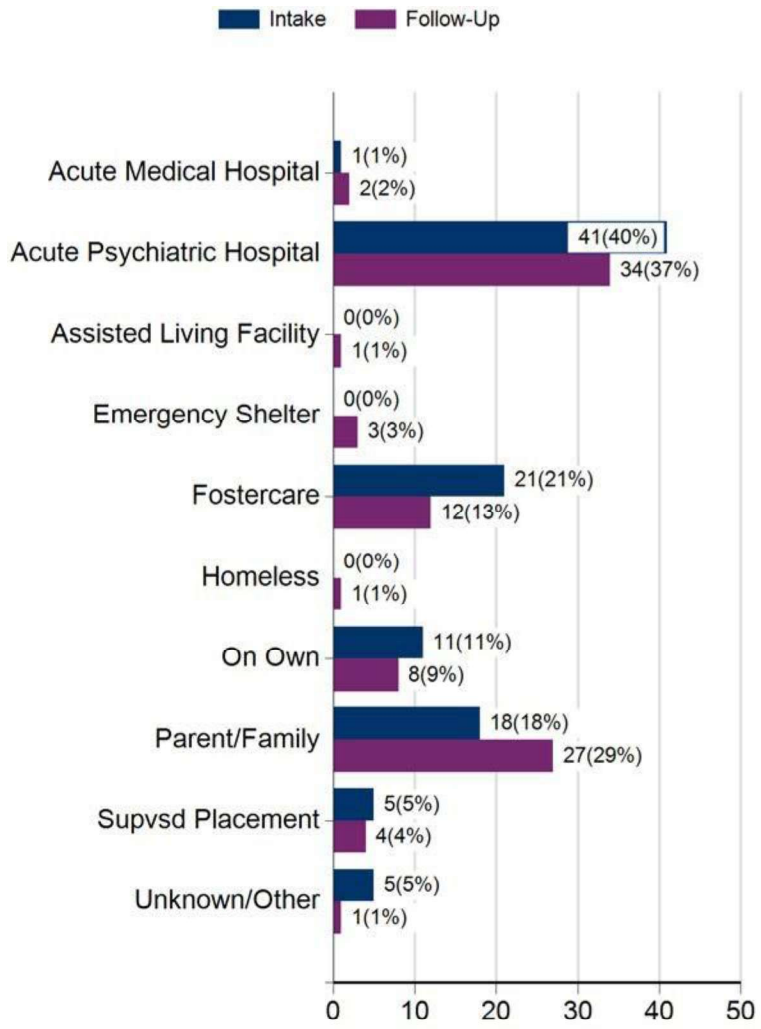
## Outcomes: Primary Care Physician (33MUFA)




Intake: Most adults (60.2%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 53 consumers that did not have a PCP at intake, 29 (55.0%) obtained a PCP while in the program.

## Outcomes: Residential & Discontinuance (33MUFA)




| Discontinuation Reason | Count | % |
|---|---|---|
| Deceased | 1 | 2% |
| Justice system | 1 | 2% |
| Met goals | 14 | 30% |
| Moved out of county/area | 7 | 15% |
| Needs residential care | 1 | 2% |
| Partner cannot be located | 11 | 23% |
| Partner left program | 12 | 26% |
| **Total** | **47** | **100%** |

## Length of FSP Partnership for: 33MUFA

| Adult Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| >= 1 Year and < 2 Years | 2 | 7 | 9 | 9.00% |
| >= 2 Years and <3 Years | 4 | 2 | 6 | 6.00% |
| >= 3 Years and < 4 Years | 4 | 5 | 9 | 9.00% |
| >= 4 Years and < 5 years | 1 | 2 | 3 | 3.00% |
| >= 90 days and < 1 Year | 27 | 19 | 46 | 46.00% |
| Under 90 days | 21 | 6 | 27 | 27.00% |
| **Total Consumer Enrollments** | **59** | **41** | **100** | |

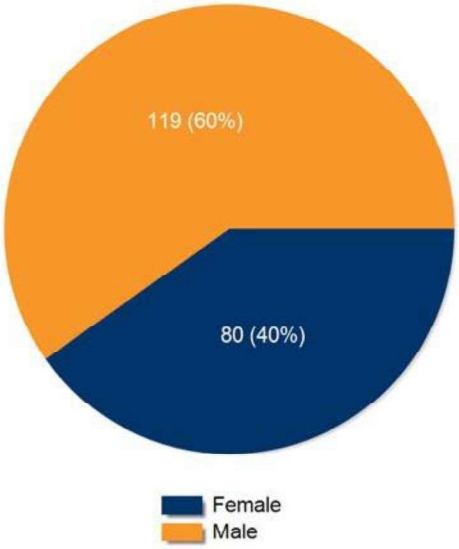
## Demographics

60% of consumers were male and 40% were female.

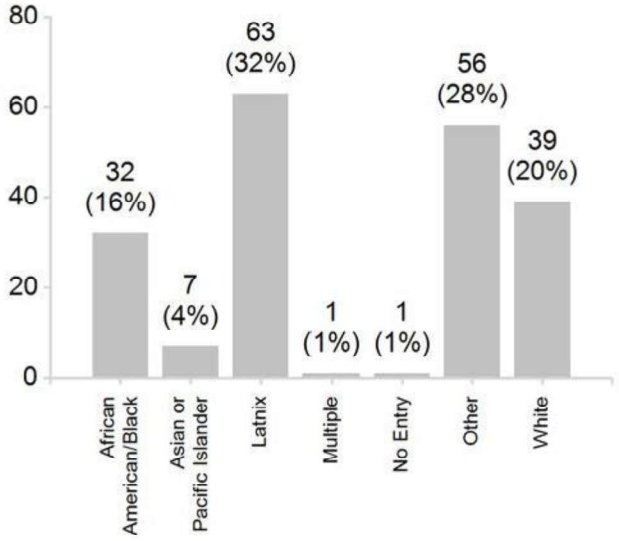
20% of consumers were White, 0% of consumers were Hispanic/Latinx and 16% of consumers were Black/African American.

22% of consumers were 40 to 49 years old.

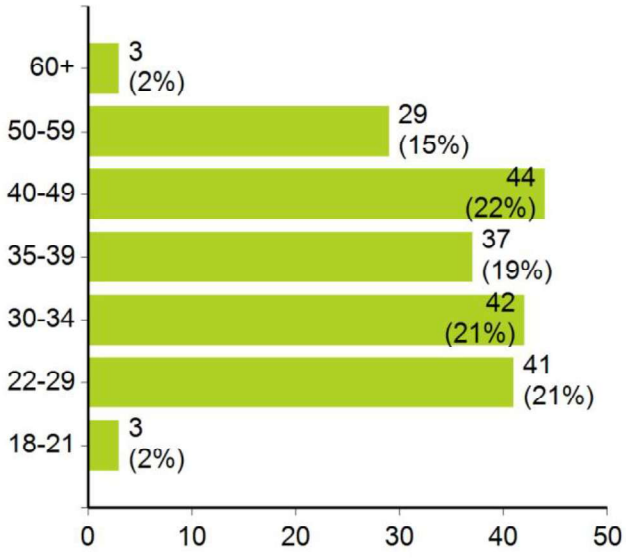
### Gender



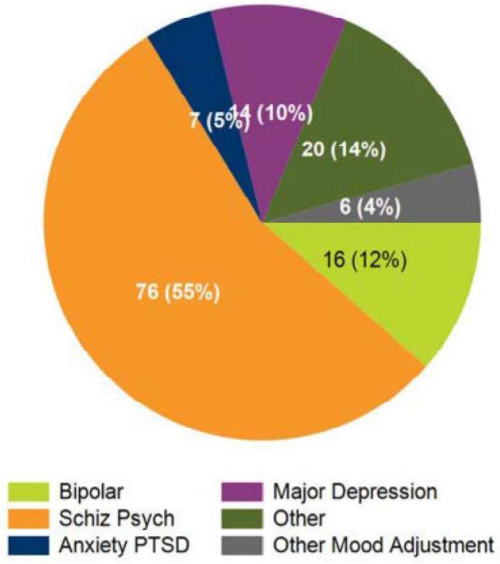

### Race/Ethnicity




### Age




### Diagnosis



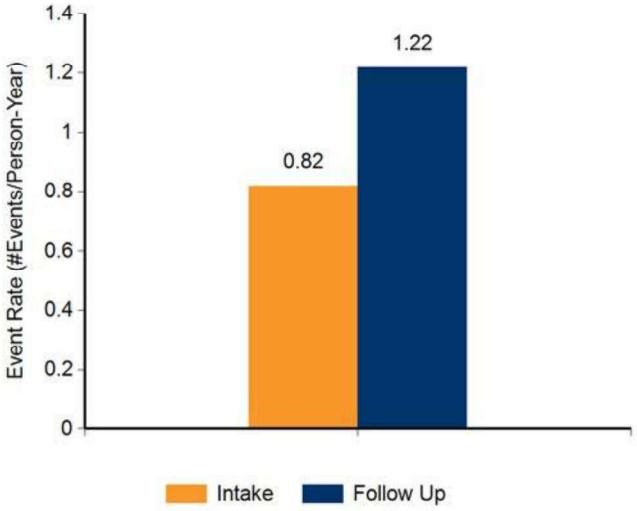
## Service Detail: 3315FA

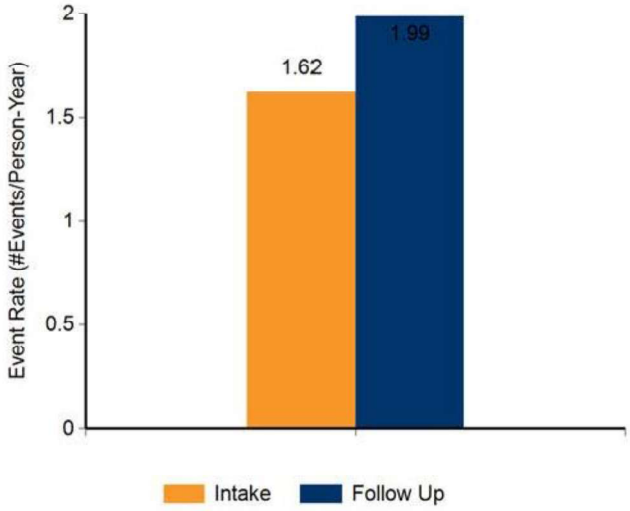
| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 6 (11%) | 11 (18%) | 15 (22%) | 12 (19%) | 16 (27%) | 19 (35%) | 19 (30%) | 18 (25%) | 27 (30%) | 23 (28%) | 23 (31%) | 29 (38%) |
| 2-3 | 12 (23%) | 15 (24%) | 20 (29%) | 19 (30%) | 14 (23%) | 12 (22%) | 15 (24%) | 18 (25%) | 27 (30%) | 19 (23%) | 19 (25%) | 20 (26%) |
| 4-7 | 22 (42%) | 19 (31%) | 19 (28%) | 19 (30%) | 21 (35%) | 14 (25%) | 15 (24%) | 17 (23%) | 18 (20%) | 22 (27%) | 13 (17%) | 17 (22%) |
| 8-13 | 10 (19%) | 9 (15%) | 10 (15%) | 8 (13%) | 7 (12%) | 5 (9%) | 9 (14%) | 12 (16%) | 13 (14%) | 10 (12%) | 11 (15%) | 3 (4%) |
| 14-19 | 2 (4%) | 6 (10%) | 3 (4%) | 3 (5%) | 1 (2%) | 4 (7%) | 3 (5%) | 4 (5%) | 5 (5%) | 4 (5%) | 4 (5%) | 3 (4%) |
| 20-25 | 1 (2%) | 0 (0%) | 0 (0%) | 1 (2%) | 1 (2%) | 0 (0%) | 1 (2%) | 3 (4%) | 0 (0%) | 2 (2%) | 4 (5%) | 3 (4%) |
| 26-31 | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (2%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (1%) |
| 32+ | 0 (0%) | 2 (3%) | 1 (1%) | 1 (2%) | 0 (0%) | 0 (0%) | 1 (2%) | 1 (1%) | 1 (1%) | 1 (1%) | 1 (1%) | 0 (0%) |
| Monthly Total | 53 | 62 | 68 | 63 | 60 | 55 | 63 | 73 | 91 | 81 | 75 | 76 |

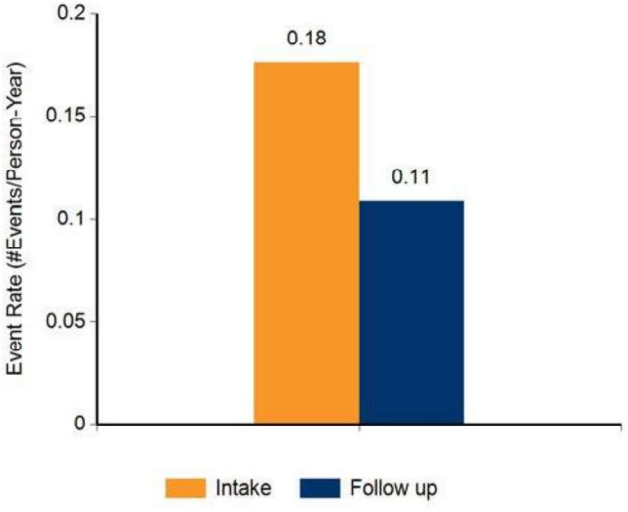
| Type of Service | # of Adult | % of Adult | # of Svcs | Avg. # Svcs |
|---|---|---|---|---|
| Assessment Services | 23 | 4% | 23 | 1.00 |
| Case Management | 114 | 19% | 610 | 5.35 |
| Client Supportive Services | 3 | 0% | 5 | 1.67 |
| Collateral Services | 1 | 0% | 1 | 1.00 |
| Crisis | 4 | 1% | 8 | 2.00 |
| Family Therapy | 1 | 0% | 1 | 1.00 |
| Individual Therapy | 39 | 6% | 420 | 10.77 |
| Medication MD Services | 89 | 15% | 245 | 2.75 |
| Medication Therapeutic Services | 33 | 5% | 94 | 2.85 |
| Mental Health Services-Group | 2 | 0% | 5 | 2.50 |
| Mental Health Services-Individual | 131 | 22% | 2,092 | 15.97 |
| Non Face to Face MD | 5 | 1% | 5 | 1.00 |
| Peer MH Education Groups | 16 | 3% | 69 | 4.31 |
| Peer MH Engagement | 65 | 11% | 274 | 4.22 |
| Peer MH Therapeutic Activity | 73 | 12% | 436 | 5.97 |
| Psychiatric Assessment | 8 | 1% | 9 | 1.13 |

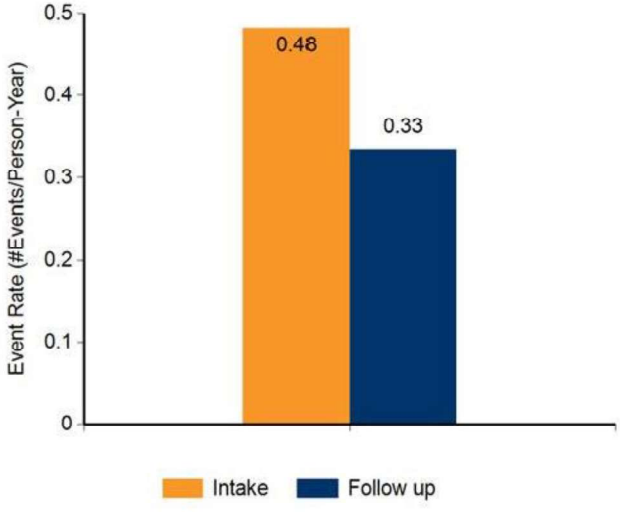
## Outcomes for 3315FA

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

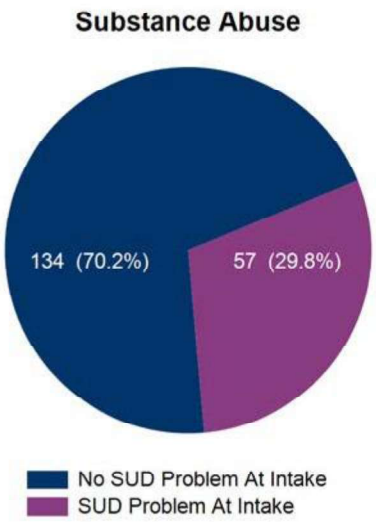


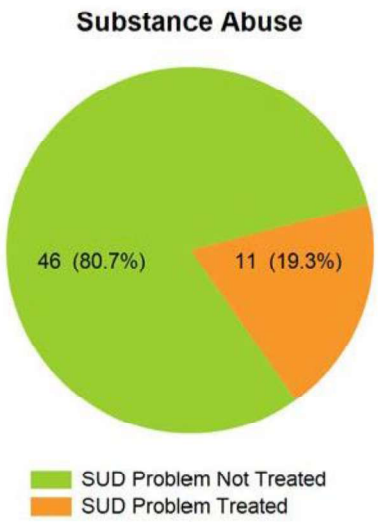



## Outcomes: Substance Use (3315FA)

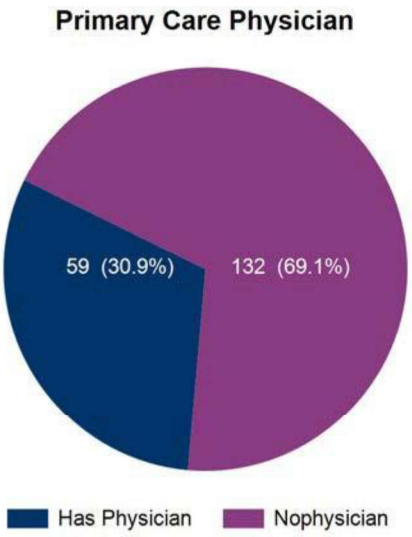



Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (29.8%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 15.2% (7) of the 46 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 15 consumers not identified at intake were noted to have an SU problem on follow-up and 15.0% of them were reported to be in SU services on follow-up.

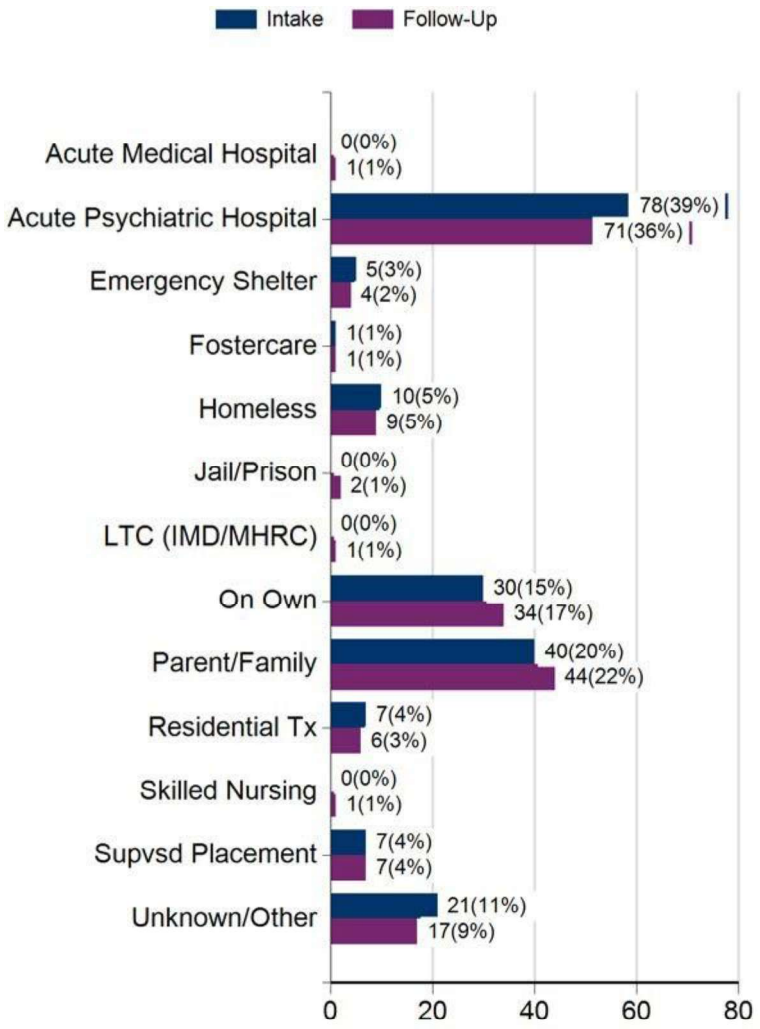
## Outcomes: Primary Care Physician (3315FA)




Intake: Most adults (69.1%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 132 consumers that did not have a PCP at intake, 40 (30.0%) obtained a PCP while in the program.

## Outcomes: Residential & Discontinuance (3315FA)




| Discontinuation Reason | Count | % |
|---|---|---|
| Deceased | 1 | 1% |
| Justice system | 3 | 3% |
| Met goals | 8 | 9% |
| Moved out of county/area | 9 | 10% |
| Needs residential care | 5 | 5% |
| Partner cannot be located | 43 | 47% |
| Partner left program | 23 | 25% |
| **Total** | **92** | **100%** |

## Length of FSP Partnership for: 3315FA

| Adult Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| >= 1 Year and < 2 Years | 2 | 16 | 18 | 9.05% |
| >= 2 Years and <3 Years | 2 | 3 | 5 | 2.51% |
| >= 3 Years and < 4 Years | 0 | 7 | 7 | 3.52% |
| >= 90 days and < 1 Year | 54 | 42 | 96 | 48.24% |
| Under 90 days | 39 | 34 | 73 | 36.68% |
| **Total Consumer Enrollments** | **97** | **102** | **199** | |

## FSP Adult demographics and Outcomes for: 3373FA
## Served by this reporting unit: 366 Enrollment: 378

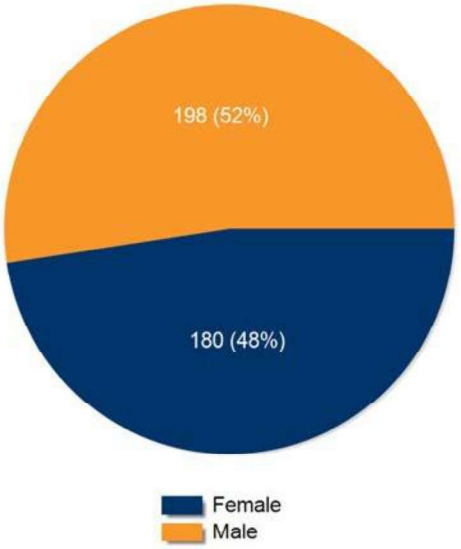
### Demographics

52% of consumers were male and 48% were female.

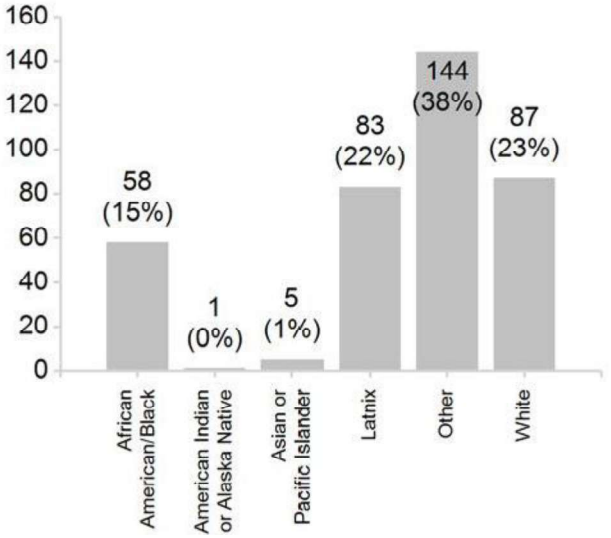
23% of consumers were White, 0% of consumers were Hispanic/Latinx and 15% of consumers were Black/African American.

28% of consumers were 40 to 49 years old.

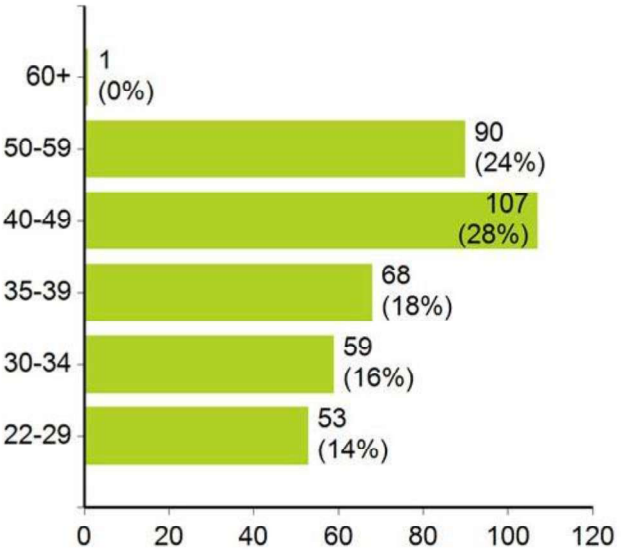
**Gender**



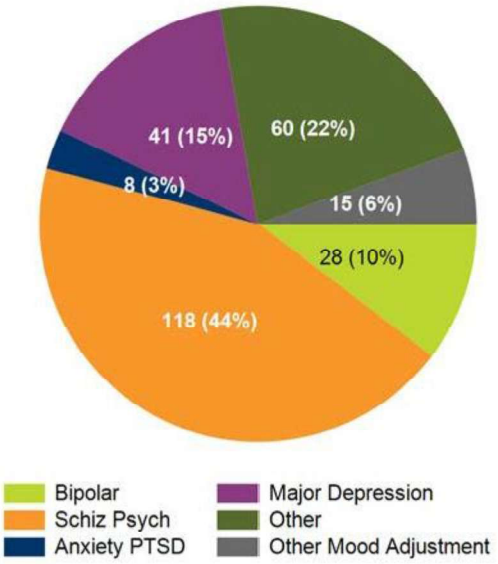

**Race/Ethnicity**




**Age**




**Diagnosis**



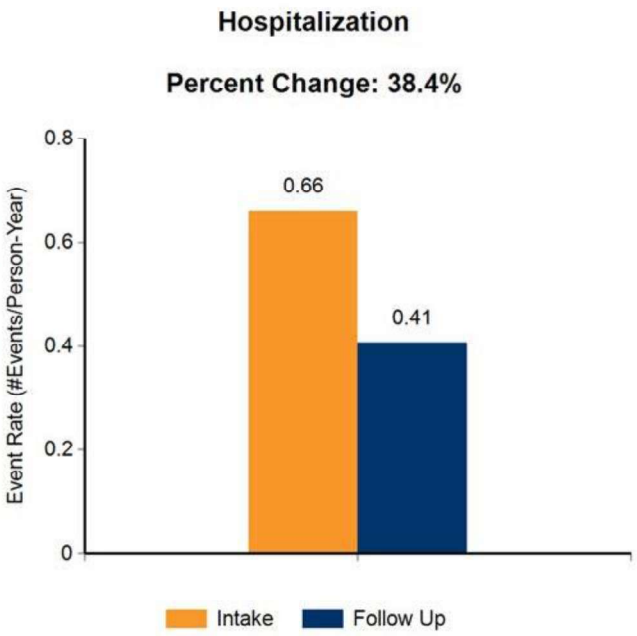
## Service Detail: 3373FA

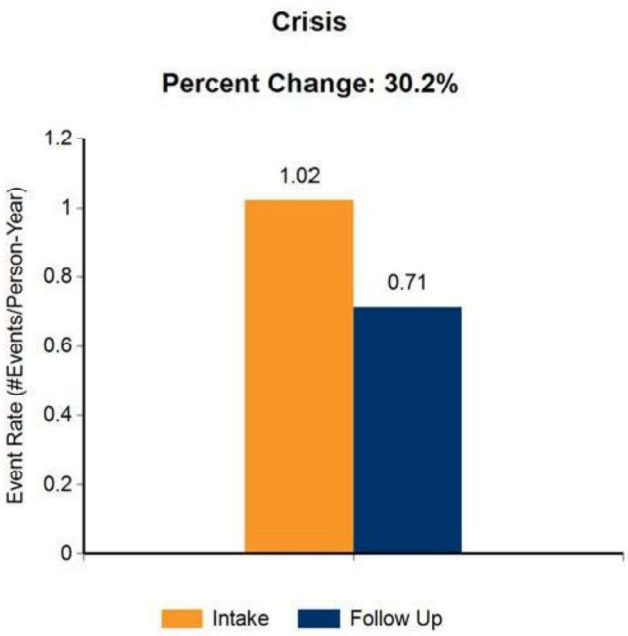
| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 25 (16%) | 11 (7%) | 14 (10%) | 20 (14%) | 16 (11%) | 23 (16%) | 21 (14%) | 8 (6%) | 20 (12%) | 29 (16%) | 22 (13%) | 23 (14%) |
| 2-3 | 25 (16%) | 34 (22%) | 28 (19%) | 27 (19%) | 30 (21%) | 25 (17%) | 27 (18%) | 31 (22%) | 33 (20%) | 34 (18%) | 22 (13%) | 36 (21%) |
| 4-7 | 50 (31%) | 33 (21%) | 53 (37%) | 43 (30%) | 44 (31%) | 51 (35%) | 45 (29%) | 43 (31%) | 48 (30%) | 39 (21%) | 32 (18%) | 40 (24%) |
| 8-13 | 35 (22%) | 52 (33%) | 30 (21%) | 40 (28%) | 36 (26%) | 39 (27%) | 39 (25%) | 38 (27%) | 33 (20%) | 37 (20%) | 49 (28%) | 36 (21%) |
| 14-19 | 16 (10%) | 16 (10%) | 15 (10%) | 9 (6%) | 10 (7%) | 7 (5%) | 14 (9%) | 14 (10%) | 16 (10%) | 21 (11%) | 19 (11%) | 20 (12%) |
| 20-25 | 4 (3%) | 5 (3%) | 3 (2%) | 3 (2%) | 3 (2%) | 1 (1%) | 3 (2%) | 2 (1%) | 9 (6%) | 15 (8%) | 17 (10%) | 6 (4%) |
| 26-31 | 0 (0%) | 1 (1%) | 1 (1%) | 0 (0%) | 1 (1%) | 1 (1%) | 3 (2%) | 2 (1%) | 2 (1%) | 5 (3%) | 7 (4%) | 5 (3%) |
| 32+ | 4 (3%) | 4 (3%) | 1 (1%) | 2 (1%) | 1 (1%) | 0 (0%) | 1 (1%) | 1 (1%) | 0 (0%) | 5 (3%) | 5 (3%) | 4 (2%) |
| Monthly Total | 159 | 156 | 145 | 144 | 141 | 147 | 153 | 139 | 161 | 185 | 173 | 170 |

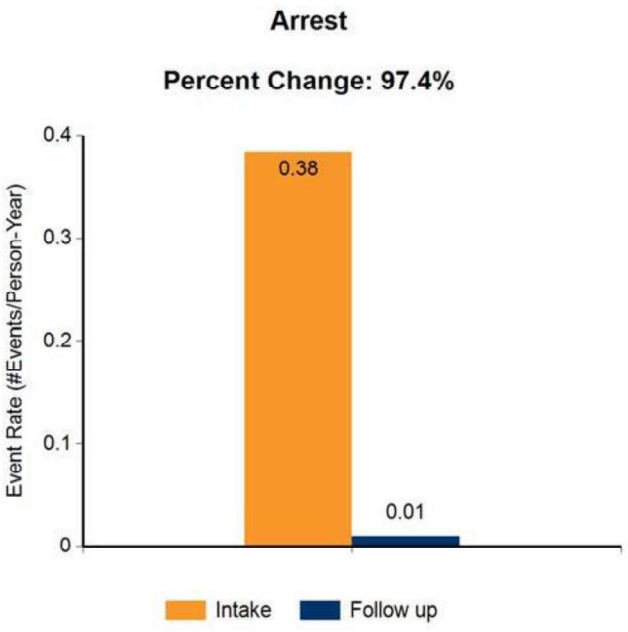
| Type of Service | # of Adult | % of Adult | # of Svcs | Avg. # Svcs |
|---|---|---|---|---|
| Assessment Services | 123 | 8% | 157 | 1.28 |
| Case Management | 313 | 21% | 4,246 | 13.57 |
| Crisis | 24 | 2% | 47 | 1.96 |
| Family Therapy | 1 | 0% | 1 | 1.00 |
| Individual Therapy | 59 | 4% | 443 | 7.51 |
| Medication MD Services | 143 | 9% | 615 | 4.30 |
| Medication Therapeutic Services | 175 | 12% | 2,028 | 11.59 |
| Mental Health Services-Group | 80 | 5% | 623 | 7.79 |
| Mental Health Services-Individual | 265 | 18% | 4,562 | 17.22 |
| Non Face to Face MD | 42 | 3% | 85 | 2.02 |
| Peer MH Education Groups | 48 | 3% | 351 | 7.31 |
| Peer MH Engagement | 49 | 3% | 545 | 11.12 |
| Peer MH Therapeutic Activity | 102 | 7% | 892 | 8.75 |
| Psychiatric Assessment | 86 | 6% | 89 | 1.03 |

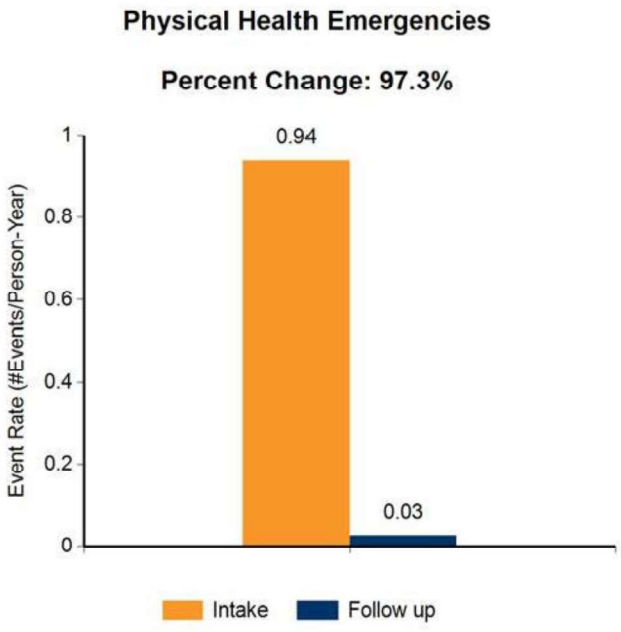
## Outcomes for 3373FA

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

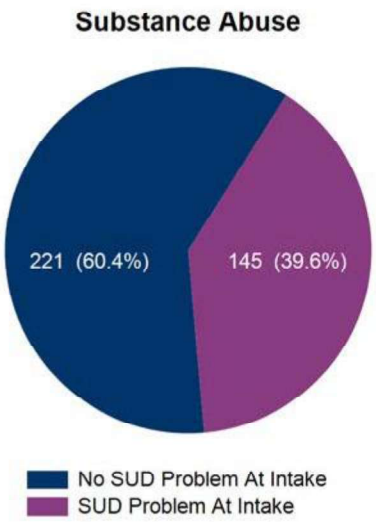


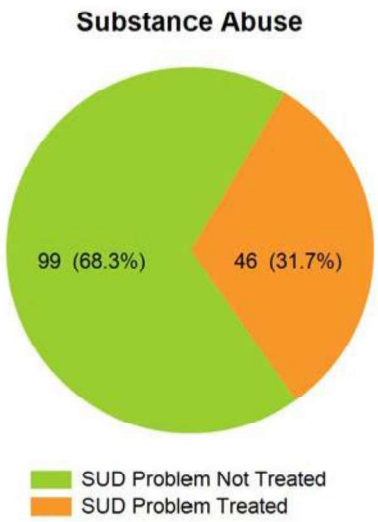



## Outcomes: Substance Use (3373FA)

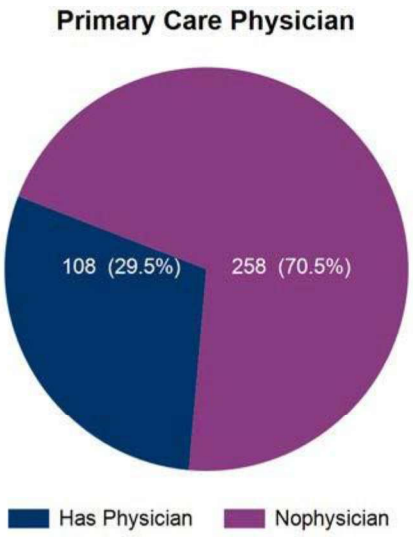



Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (39.6%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 17.2% (17) of the 99 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 65 consumers not identified at intake were noted to have an SU problem on follow-up and 17.0% of them were reported to be in SU services on follow-up.

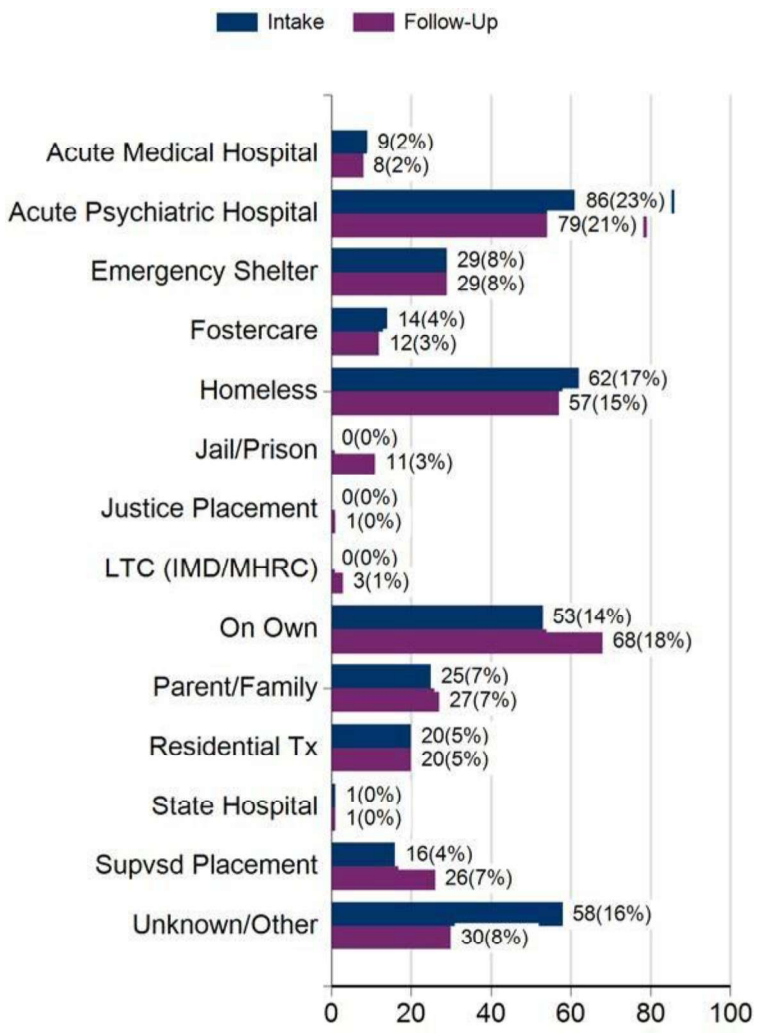
## Outcomes: Primary Care Physician (3373FA)




Intake: Most adults (70.5%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 258 consumers that did not have a PCP at intake, 100 (39.0%) obtained a PCP while in the program.

## Outcomes: Residential & Discontinuance (3373FA)




| Discontinuation Reason | Count | % |
|---|---|---|
| Deceased | 5 | 3% |
| Justice system | 10 | 6% |
| Met goals | 30 | 19% |
| Moved out of county/area | 15 | 9% |
| Needs residential care | 2 | 1% |
| Other | 1 | 1% |
| Partner cannot be located | 62 | 39% |
| Partner left program | 24 | 15% |
| Target criteria not met | 11 | 7% |
| **Total** | **160** | **100%** |

## Length of FSP Partnership for: 3373FA

| Adult Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| >= 1 Year and < 2 Years | 19 | 15 | 34 | 8.99% |
| >= 2 Years and <3 Years | 19 | 11 | 30 | 7.94% |
| >= 3 Years and < 4 Years | 3 | 17 | 20 | 5.29% |
| >= 4 Years and < 5 years | 3 | 3 | 6 | 1.59% |
| >= 90 days and < 1 Year | 93 | 75 | 168 | 44.44% |
| >=5 Years and < 6 years | 3 | 7 | 10 | 2.65% |
| >=6 Years+ | 6 | 11 | 17 | 4.50% |
| Under 90 days | 44 | 49 | 93 | 24.60% |
| **Total Consumer Enrollments** | **190** | **188** | **378** | |

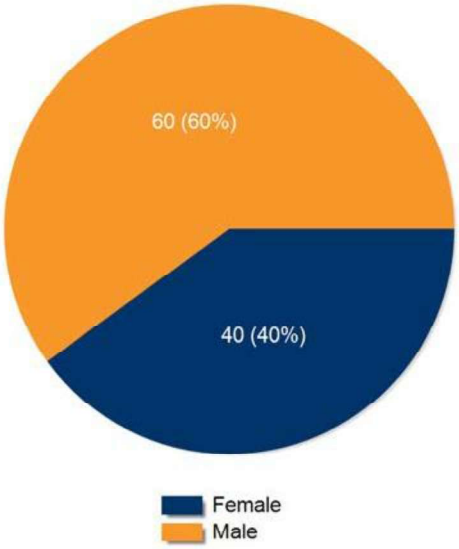
## Demographics

60% of consumers were male and 40% were female.

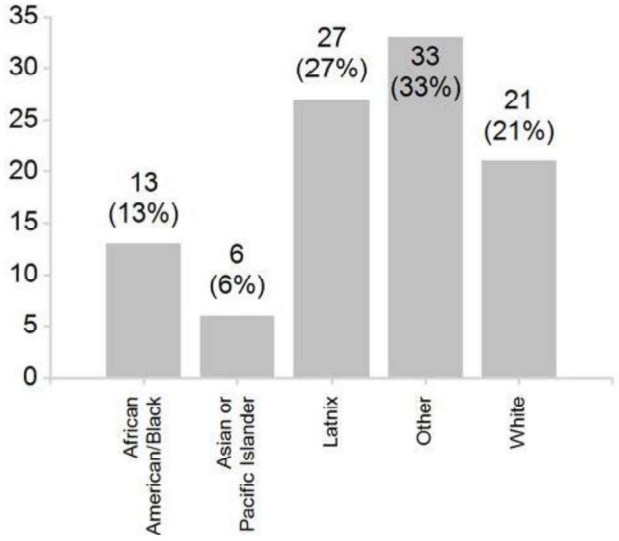
21% of consumers were White, 0% of consumers were Hispanic/Latinx and 13% of consumers were Black/African American.

27% of consumers were 40 to 49 years old.

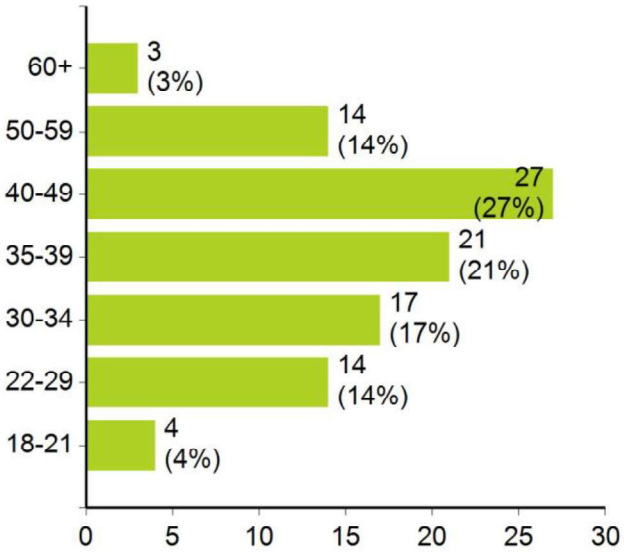
### Gender



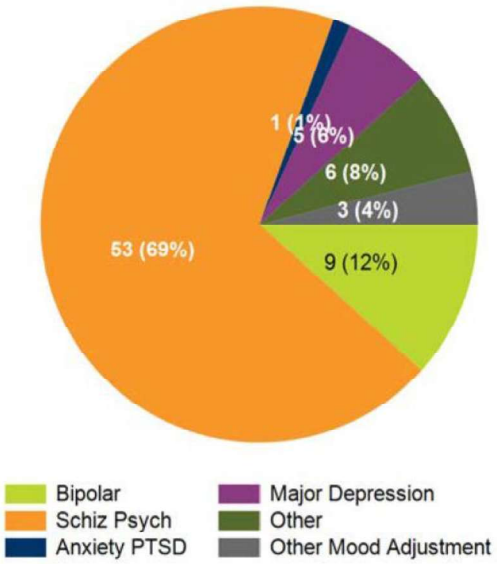

### Race/Ethnicity




### Age




### Diagnosis



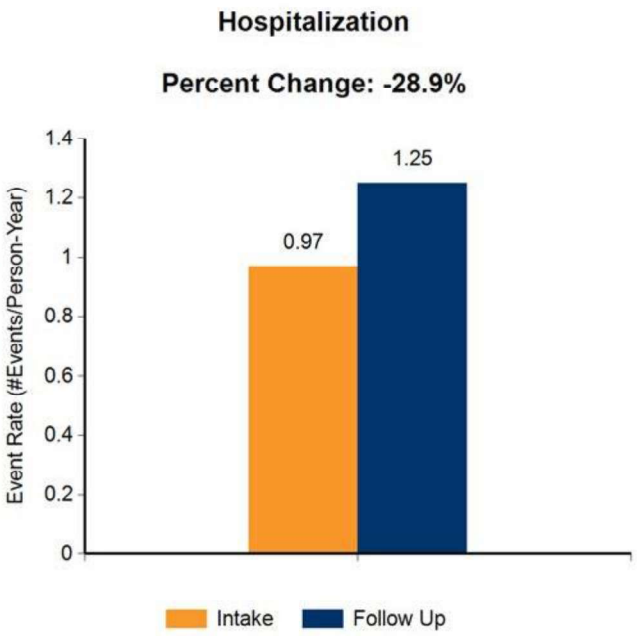
## Service Detail: 33IGFA

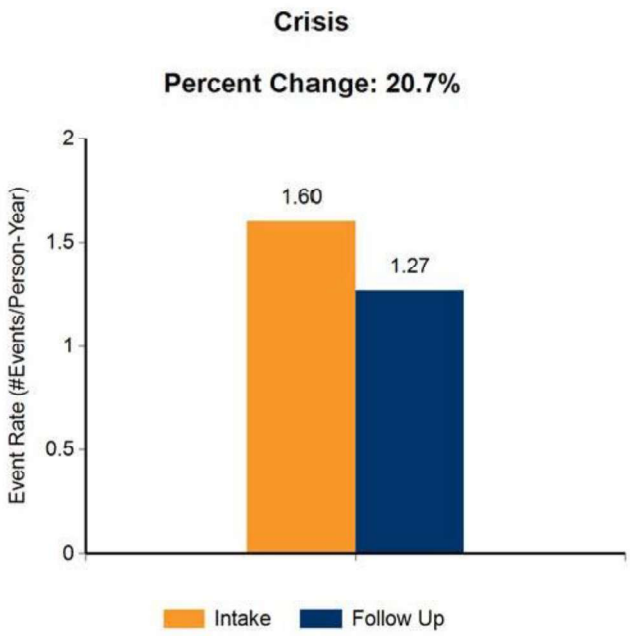
| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 9 (41%) | 9 (47%) | 10 (91%) | 16 (70%) | 15 (65%) | 19 (83%) | 3 (27%) | 5 (31%) | 11 (73%) | 7 (33%) | 10 (38%) | 17 (57%) |
| 2-3 | 8 (36%) | 5 (26%) | 0 (0%) | 6 (26%) | 6 (26%) | 0 (0%) | 4 (36%) | 9 (56%) | 2 (13%) | 8 (38%) | 11 (42%) | 10 (33%) |
| 4-7 | 4 (18%) | 3 (16%) | 0 (0%) | 1 (4%) | 1 (4%) | 4 (17%) | 4 (36%) | 2 (13%) | 2 (13%) | 5 (24%) | 4 (15%) | 2 (7%) |
| 8-13 | 1 (5%) | 2 (11%) | 1 (9%) | 0 (0%) | 1 (4%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (5%) | 1 (4%) | 1 (3%) |
| Monthly Total | 22 | 19 | 11 | 23 | 23 | 23 | 11 | 16 | 15 | 21 | 26 | 30 |

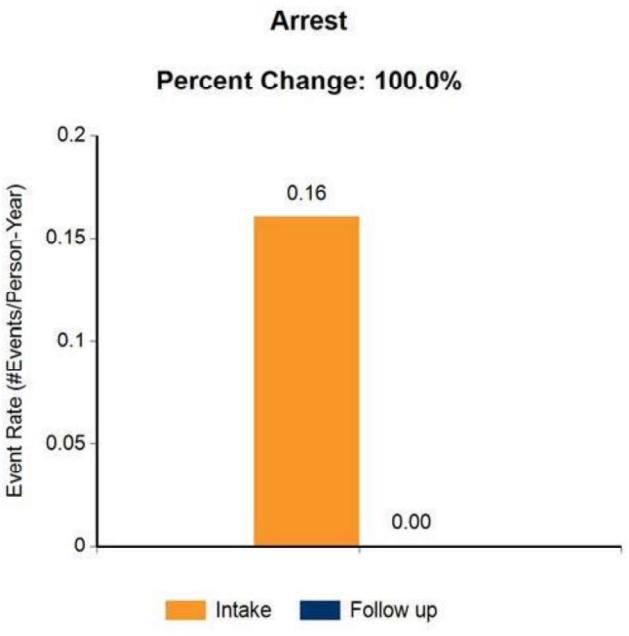
| Type of Service | # of Adult | % of Adult | # of Svcs | Avg. # Svcs |
|---|---|---|---|---|
| Assessment Services | 1 | 1% | 1 | 1.00 |
| Case Management | 75 | 41% | 248 | 3.31 |
| Collateral Services | 1 | 1% | 2 | 2.00 |
| Crisis | 1 | 1% | 2 | 2.00 |
| Individual Therapy | 6 | 3% | 34 | 5.67 |
| Medication MD Services | 20 | 11% | 29 | 1.45 |
| Medication Therapeutic Services | 5 | 3% | 7 | 1.40 |
| Mental Health Services-Individual | 32 | 17% | 88 | 2.75 |
| Non Face to Face MD | 11 | 6% | 17 | 1.55 |
| Non Family Collateral | 1 | 1% | 1 | 1.00 |
| Peer MH Engagement | 5 | 3% | 8 | 1.60 |
| Peer MH Therapeutic Activity | 16 | 9% | 57 | 3.56 |
| Psychiatric Assessment | 11 | 6% | 11 | 1.00 |

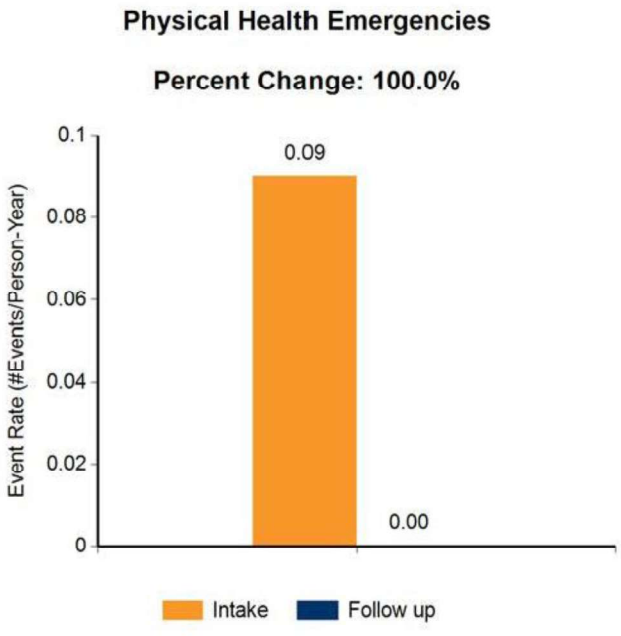
## Outcomes for 33IGFA

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.



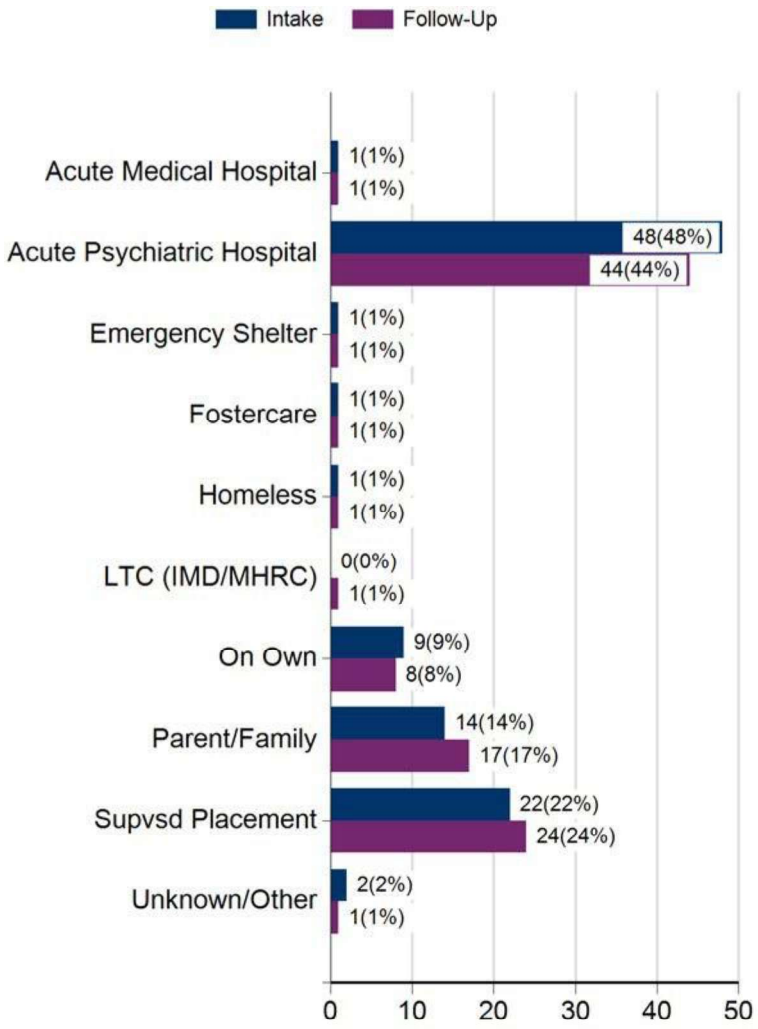



## Outcomes: Residential & Discontinuance (33IGFA)

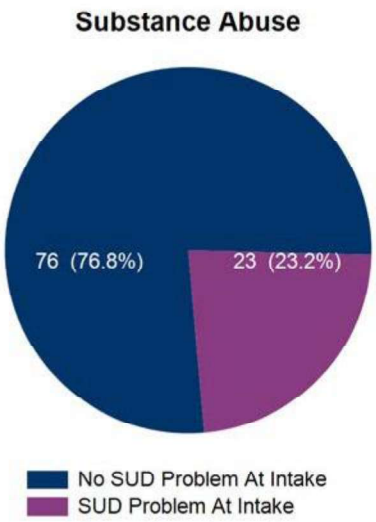
| Discontinuation Reason | Count | % |
|---|---|---|
| Total | 0 | 100% |

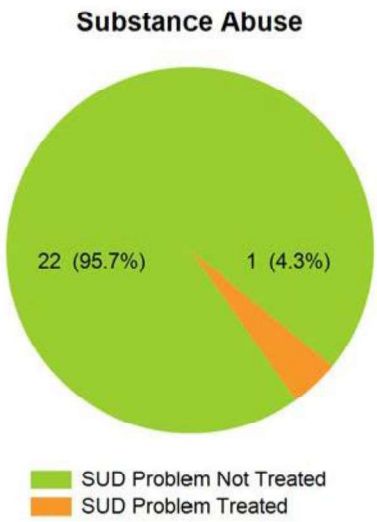



## Length of FSP Partnership for: 33IGFA

| Adult Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| >= 1 Year and < 2 Years | 0 | 10 | 10 | 10.00% |
| >= 2 Years and <3 Years | 2 | 1 | 3 | 3.00% |
| >= 3 Years and < 4 Years | 0 | 18 | 18 | 18.00% |
| >= 90 days and < 1 Year | 3 | 48 | 51 | 51.00% |
| Under 90 days | 2 | 16 | 18 | 18.00% |
| **Total Consumer Enrollments** | **7** | **93** | **100** | |

## Outcomes: Substance Use (33IGFA)

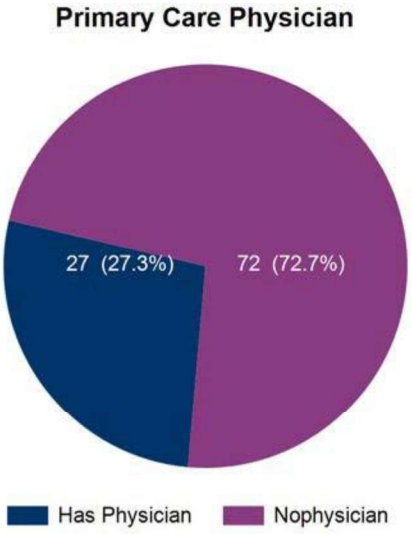



Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (23.2%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 4.5% (1) of the 22 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 0 consumers not identified at intake were noted to have an SU problem on follow-up and 5.0% of them were reported to be in SU services on follow-up.

## Outcomes: Primary Care Physician (33IGFA)




Intake: Most adults (72.7%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 72 consumers that did not have a PCP at intake, 5 (7.0%) obtained a PCP while in the program.

# Older Adults Full-Service Partnership (FSP) /SMART

## Western Region Older Adult Full-Service Partnership

The Western Region Older Adult Full-Service Partnership (FSP), also referred to as Specialty Multidisciplinary Aggressive Response Treatment (SMART) in the Western region, is a program that serves approximately 216 members who have a history of difficulty engaging in or sustaining treatment in a traditional outpatient behavioral health setting. This program addresses the needs of older adult members who are homeless or at risk of homelessness and suffer from severe and persistent mental illness. Another focus of service is addressing the complicated needs of community members with a history of intermittent stays in acute and/or longer-term care institutions. The Western SMART FSP team utilized a "whatever it takes approach to meet the members where they are in their recovery, whether it is contemplation, acceptance, readiness, etc. The team collaborates with community resources to address social determinants such as the consumer's social, emotional, vocational, educational, and housing needs and/or their support system. An emphasis is placed on integrated care whereby staff connect members to primary care providers, Community Health Centers (CHCs), and other medical resources such as In-Home Supportive Services (IHSS), Enhanced Care Management (ECM), and Inland Empire Health Plan (IEHP) teams, etc.

Services are provided by a multidisciplinary treatment team that includes a Behavioral Health Services Supervisor, Psychiatrists, Clinical Therapists, Behavioral Health Specialists, Registered and Licensed Vocational Nurses, Peer Support Specialists, Family Advocates and Community Service Assistants. Members are assigned to their specific wellness partners and are encouraged to be coauthors of their recovery plan. When facing the reality of the vicissitudes of pursuing wellness, members are supported and encouraged during their journey in an attempt to assist them with identifying healthier ways of responding to life's ongoing challenges. The Western region staff provides a multitude of therapy groups and individual therapy (DBT, Seeking Safety, Grief & Loss, WRAP, COLOR for co-occurring members, Healthy Relationships, etc.) in addition to intense case management, substance abuse counseling, nursing support, psychiatry follow up, peer support and family advocacy. In addition, the nursing team facilitates a "Living Well with Chronic Conditions" group, utilizing coaching and psychoeducation on various topics, which began during the past year.

The SMART FSP team partners with several community entities every week, including Adult Protective Services (APS) embedded staff, IEHP/Molina/ECM teams for integrated care, the Representative Payee's office, Riverside County HHOPE Housing Program and the Housing Authority, in addition to the Office on Aging, Substance Abuse Prevention and Treatment/Arlington Recovery Center-Riverside (SAPT/ARC) and Sobering Center, etc. The collaboration with housing resources and the supportive aspect of re-engagement are essential elements of this program. Another key feature of this program is that staff are trained to be culturally aware of the unique needs of the older adult population and understand this population's perception of medical and behavioral health care. Fostering autonomy of decision-

making is essential in establishing and maintaining consumer trust in the therapeutic relationship. Clinic Supervisors implemented a quarterly meeting in Fall 2023 with the SAPT supervisors and staff to address barriers to treatment for older adult members. These meetings have been instrumental in communicating needs for discharge planning and ongoing treatment.

The Western Region FSP program currently serves 216 FSP members as of January 9, 2025, with some discharging and re-enrolling. The census increased by about 74 members during the past year as the clinic opened an Inpatient Treatment Facility/Hospital (ITF) and admitted clients into FSP programs. Our clinical therapists collaborate closely with ITF staff social workers to engage members for at least 60 days. The clinic Family Advocate has also recently begun to expand engagement by meeting with members at the hospital before discharge to help facilitate a smoother transition to services post-discharge. Our Senior Clinical Therapist and clinic supervisors have successfully tracked the ITF referrals opened to FSP, which have approached 100 since implementation in January 2023.

Members make consistent attendance in the program a priority in their recovery. Members who participate in this program experience a significant reduction in arrests, mental health emergencies, physical health emergencies, homelessness, and acute hospitalizations. Additionally, these FSP participants exhibit an impressive willingness to begin addressing substance abuse issues, especially since the program has had two dedicated substance abuse counselors who have linked many members to inpatient and outpatient treatment, in addition to 1:1 counseling, coaching, and education. The substance abuse counselors continue to facilitate a “Living in Balance”/COLORs group for Co-Occurring Disorders, which is an evidenced-based curriculum modeled after the 12-step program. A very significant gain is that after members participate in treatment, they often show a decrease in living in emergency shelters or homeless settings, and many can regain stable housing and permanent supportive housing. Once their basic needs are met, members can pursue higher-level goals, such as employment or volunteer work. Our FSP Substance Abuse counselors continue to work 1:1 with the members to assist with linkage to the ARC/Sobering Center and residential treatment. Many members have participated in outpatient/residential treatment and maintained sobriety in the past year.

During the past year, a Family Advocate group called “Food for the Heart” was implemented. This group assists clients who are experiencing food insufficiencies. The Family Advocate links members to food banks and other resources to meet their needs so that they are empowered to maintain independence and self-sufficiency. This is a popular, sought-after group. Members consistently provide feedback that this group offsets their increased living expenses from recent inflationary years.

**Plans for FY 2024-2025 are to continue the 3-Year Plan**

goal to continue to increase the number of FSP members regionally by at least 10% each year. The program receives between 15 and 20 new referrals each week from various sources, such as APS, Office on Aging, self-referrals, ITF/hospital discharges, transfers from other programs, etc., and has seen an approximate 42% increase in consumer referrals.

We also hope to see new innovative, evidence-based practices implemented for older adults (e.g., mindfulness-based stress reduction, Tai Chi, etc.). Staff continue to introduce members

to technology through our Help@Hand Tech Innovations Dept., including participation in the A4i project, many of whom completed the program and received monetary incentives. With the assistance of staff, members have also been enrolled in the Whole Person Health Portal and have completed surveys to obtain financial incentives for participating. Clinic supervisors are proposing/recommending a request for a clinic Nurse Practitioner (NP) to enhance and increase our integrated care services. Adding a nurse practitioner would be invaluable to the clinic as the psychiatrists could more efficiently step down their less acute clients to manage NPs and decrease caseloads. NPs could assist with prescribing/furnishing medications and perform psychiatric diagnostic assessments, overall physical health assessments, TB tests, etc., which can expedite tasks/forms required for housing, disability, benefits, etc.

### *Mid-County Region: SMART*

The Mid-County Older Adult Full-Service Partnership (FSP) programs, also known as Specialty Multidisciplinary Aggressive Response Treatment (SMART) in Mid-County and Southwest Mid-County, currently serves approximately 275 FSP members as of January 9, 2025, with some discharging and re-enrolling. Overall, outcomes in arrest and mental/physical health emergencies, as well as acute psychiatric hospitalizations, were significantly reduced. Additionally, a booming increase in linkage to primary services supports the success of integrative care and the reduction of key medical crisis events. Both FSP programs for the Mid-County region mirror the services provided in the western region, such as the Older Adult FSP SMART program. The target populations are those who are currently homeless or at risk of being homeless and are cycling in and out of jail or prison, as well as cycling in and out of psychiatric hospitals or long-term care facilities due to mental health impairments. Services are provided by a multidisciplinary treatment team, including a Behavioral Health Services Supervisor, Psychiatrists, Clinical Therapists, Behavioral Health Specialists, Registered and Licensed Vocational Nurses, Peer Support Specialists, Family Advocates, and Community Service Assistants. The Mid-County and Southwest FSP programs service multiple cities and municipalities in the southern and mid-regions of the County, bringing geographically accessible FSP services to a large community. A new resource center has enhanced the core services in the Temecula Older Adult Wellness and Recovery Clinic by adding a member computer library where clinic staff can assist members in accessing technology-based resources while improving their computer knowledge and skills.

**The 3-Year Plan goal is** to increase the number of FSP members and services regionally by 10% annually. Due to a significant increase in referrals and census over the past three fiscal years, we plan to increase staffing by adding three Clinical Therapists, two Behavioral Health Specialists, and two Peer Support Specialists over the next three fiscal years.

### *Desert: SMART*

The Desert Older Adult Full-Service Partnership (FSP), also referred to as Specialty Multidisciplinary Aggressive Response Treatment (SMART) in the Desert region, is a program that currently serves 101 FSP members as of January 9, 2025, who have a history of difficulty engaging in or sustaining treatment in a traditional outpatient behavioral health setting. The

Desert FSP program addresses the integrated needs of older adult members who are homeless or at risk of homelessness in Riverside County Desert areas who suffer from a severe and persistent mental illness. Another focus of our FSP integrated services is addressing the complicated needs of community members with a history of intermittent stays in acute and/or longer-term care institutions. The Desert SMART FSP team utilizes a "whatever it takes approach" to meet the members where they are in their recovery, whether it is contemplation, acceptance, readiness, etc. The team collaborates with community resources to meet the consumer's social, emotional, medical, vocational, educational, and housing needs and/or their support system. Integrated services are provided by a multidisciplinary treatment team that includes Behavioral Health Services supervisors, Psychiatrists, Clinical Therapists, Behavioral Health Specialists, Registered and Licensed Vocational Nurses, Peer Support Specialists, Family Advocates, and Community Service Assistants. Members are assigned to their specific wellness partners and encouraged to be coauthors and partners of their recovery plan. When facing the reality of the vicissitudes of pursuing wellness, members are supported and encouraged during their journey to assist them with identifying healthier ways of responding to life's ongoing challenges. An emphasis is placed on integrated care whereby staff connect members to primary care providers and other medical resources such as In-Home Supportive Services (IHSS), Enhanced Care Management (ECM) teams, etc.

The extreme weather in the Desert areas also complicates the dangers of not maintaining shelter, not complying with medication regimens, not following through with recommended medical care and other risk behaviors. The collaboration with housing resources and the supportive aspect of re-engagement are essential elements of this program. The Desert FSP team works collaboratively with our Behavioral Health Department's housing program (HHOPE) to provide care and support to members residing in supported living apartments in three of the regional apartment complexes (Cathedral Palm Apartments, Legacy Apartments, and Verbena Crossing Apartments). Another key feature of this program is that FSP staff are trained to be culturally aware of the unique needs of the older adult population and possess an understanding of this population's perception of medical and behavioral health care. Fostering autonomy in decision-making is essential in establishing and maintaining consumer trust in the therapeutic relationship.

The Desert FSP program serves 101 members as of January 9, 2025, with some discharging and re-enrolling. The total enrollment last year was 103. Members make consistent attendance in the program a priority in their recovery. The Desert FSP team continues to provide multiple in-person services. Members who participate in this FSP program experience a significant reduction in arrests, mental health emergencies, physical health emergencies, and acute hospitalizations. Additionally, these FSP participants exhibit an impressive willingness to begin addressing substance abuse issues, and about half initiate medical care with a primary physician. A significant gain is that these members show a decrease in living in emergency shelters or homeless settings, and many can regain stable housing.

**The 3-Year Plan goal** is to increase the number of FSP members and services regionally by 10% each year, as with the Western and Mid-County regional FSP programs. Therefore, we plan to

increase staffing in the Desert FSP program by adding two Clinical Therapists, two Behavioral Health Specialists, and one Peer Support Specialist over the next three fiscal years.

**Goals Older Adult SMART FSP:**

*Western Region*

For the 3YPE plan for FY23/24 – FY25/26, the goal is to continue increasing the number of FSP members and services regionally by 10% each year.

*Mid-County Region*

For the 3YPE plan for FY23/24 – FY25/26, the goal is to continue increasing the number of FSP members and services regionally by 10% each year.

*Desert Region*

For the 3YPE plan for FY23/24 – FY25/26, the goal is to continue increasing the number of FSP members and services regionally by 10% each year.

Riverside University HEALTH SYSTEM Behavioral Health

MENTAL HEALTH SERVICES ACT (MHSA)

FULL SERVICE PARTNERSHIP PROGRAM

# Full Service Partnership Older Adult Outcomes Report FY 2023-2024

## Background

The following report is a summary of outcome data for the Older Adult Full Service Partnership (FSP) programs. FSP program outcomes are focused on evaluating changes in a consumer's status relative to several quality of life domains. Baseline histories are obtained from consumers at enrollment into the FSP program. Follow-up data is collected on a continuous basis for key life events (e.g., hospitalizations) and is assessed periodically for other select life domains. Outcome reporting is based on comparisons between baseline and post enrollment status and provides a measure of program effectiveness.

The following report is based on FSP data collection from consumers enrolled and served in the Older Adult FSP programs beginning July 1, 2023 and ending June 30, 2024 Baseline data for this report is based on responses from each of these consumer's Partnership Assessment Form (PAF), the history of events for the 12 months before a consumer began the FSP program. Follow-up data used in this report is based on two sources. Psychiatric Hospital and Crisis emergency room data has been pulled from actual admissions to the hospital or crisis emergency room data. All other follow-up data used in this report was based on Key Event Tracking (KET) and Three Month Quarterly (3M) assessment forms completed on ImagineNet for these consumers during their enrollment in an Older Adult FSP program.

## FSP Program

Overall, the FSP programs provide an intensive level of service with regionally placed Specialty Multidisciplinary Aggressive Response Treatment (SMART) programs for Older Adults. The following report presents statistics and figures from the Older Adult FSP programs.

Four Older Adult FSP programs provide intensive case management services that offer support and crisis response services that are available 24/7. The SMART FSPs serve consumers who are unengaged and homeless or at risk of homelessness. The program also targets consumers who have a history of cycling through acute or long-term institutional treatment settings. These centers collaborate with community resources and agencies to meet the vocational, educational, social, and housing needs of consumers. Services are provided by a multi-disciplinary team that embraces the principles of recovery and resilience. The services and support that are available within SMART include: psychiatric services, vocational specialists, housing specialists, substance abuse counselors, peer support/mentorship, family education, family advocacy, educational support, and benefits specialists.

***Older Adult Enrollment and Demographics*** **—**During the 2023/2024 fiscal year from July 1, 2023 to June 30, 2024, a total of 559 older adults were served across 592 enrollments which includes re-enrollments and transfers to one or more of the older adult FSP programs. The race/ethnicity of enrollees for this fiscal year was 109 (18.4%) Latinx, 249 (42.1%) White, and 83 (14.0%) African American/Black. In each program and countywide, the most common diagnoses among older adult FSP consumers were schizophrenia/psychosis disorder 150 (34.7%). Countywide, the largest proportion of consumers were between the ages of 60 and 69 (80%) and the majority enrolled were females (55%).

***Older Adult Discontinuances*** **—**Across all of the older adult programs the most frequently reported discontinuance reason was 'Partner left program' (27%).

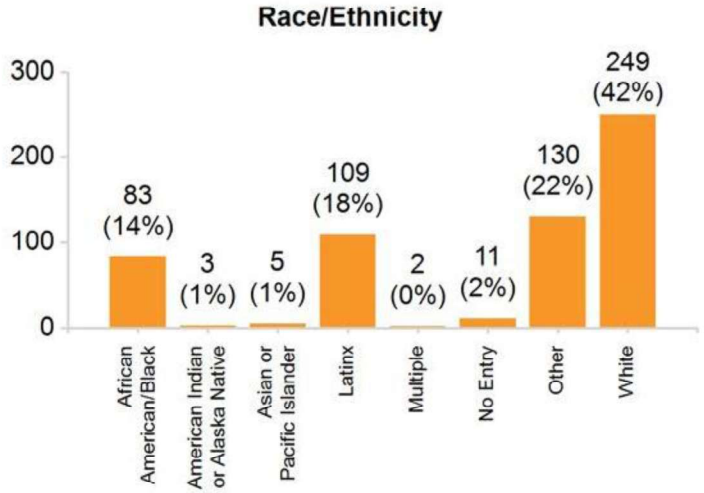
***FSP Services*** **—**In 2023/2024 fiscal year, more than half of the FSP consumers received 4-7 or 8 or more services a month. The highest average hours of services during 2023/2024 fiscal year were for Mental Health Services-Group (14.92 hours), Individual Mental Health Services (13.06 hours) and Case Management (12.93 hours).

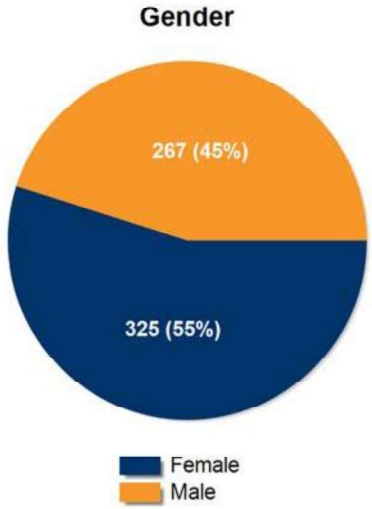
***Older Adult Outcomes*** **—**Follow-up data for all older adult programs combined showed a decrease in hospitalizations (86.05%), arrests (96.36%), physical health emergency (92.43%) and mental health emergency department visits (76.26%). Programs had 93 to 100 percent decreases in arrests between intake and follow-up. Most programs had decreases in reported hospitalizations. Emergency department visits for mental health services declined by 60% or more for consumers in most programs. Over a quarter of consumers did not have a primary care physician at the beginning of the program (26.96%). For those who did not have a primary care physican at intake, a little over half (55.70%) obtained one while in the FSP program. Although the majority of those with a co-occurring substance use problem were not receiving treatment at intake, over a quarter (28.42%) participated in substance use services while in partnership. Of the 55 additional consumers that were identified as having an active substance abuse problem during their participation in the Older Adult programs, 32(58.18%) were reported to be participating in substance use treatment services while in the FSP program.

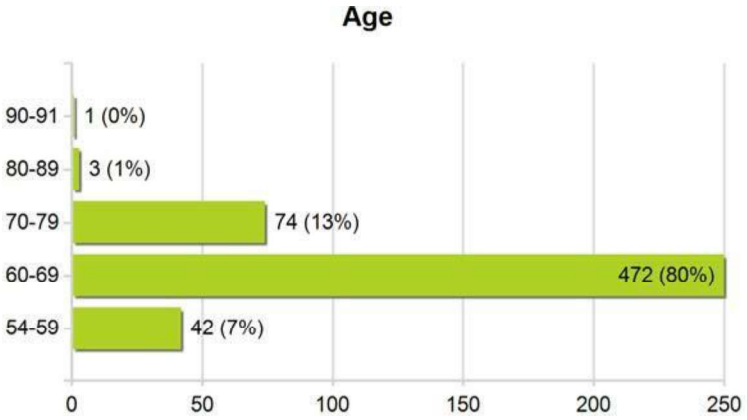
***Residential Status*** **—** Comparisons of intake status and most recent residential status showed that the percentage of consumers reported as homeless or living in emergency shelters decreased and the proportion living on their own increased.

## Demographics & Diagnosis

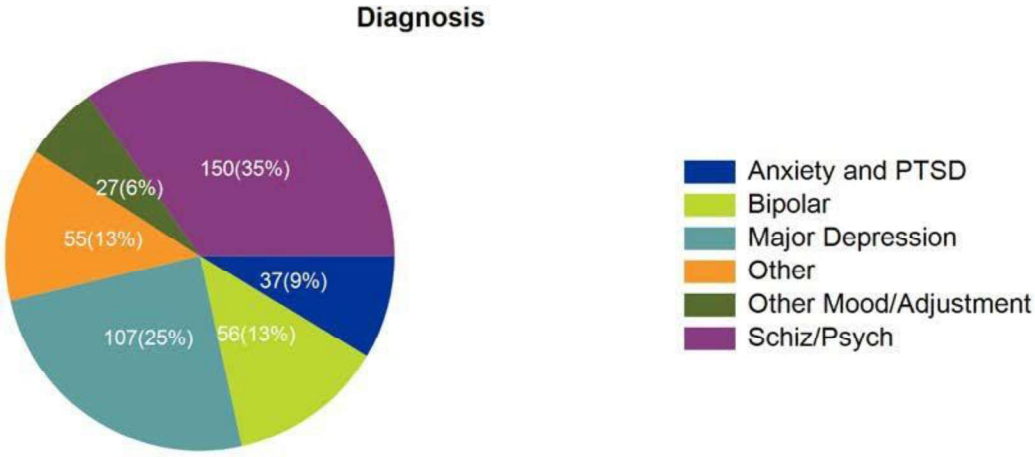
The majority served in the Older Adult FSP program in the 2023/2024 fiscal year were White 42%, which comprise a larger proportion of those served than their proportion in the Riverside County general population of 59%. The proportion of Latinx, at 18%, was lower than that in the general population of the county of 28%. The proportion of African American/Black consumers at 14% was larger than the general population of 6%. Also, more females (55%) have enrolled in the Older Adult FSP program than males (45%).




Most individuals served were between the age of 60-69 (80%). A large proportion of those served were diagnosed with Schizophrenia/Psychosis disorders (35%), Major depression (25%), or Bipolar disorder (13%).



## Length of FSP Partnership

The length of stay in years for those **592** enrolled in Older Adult FSP programs during the 2023/2024 fiscal year is shown in the tables below. For reporting time in partnership, the total time a consumer spent in each enrollment is included.

The percentage of older adults with an active/open case having time in the FSP longer than one year was 68%, while 58% of those closed had a length of stay in the FSP shorter than one year. Of all older adult FSP consumers served in FY 2023/2024, almost half had a length of stay less than two years (55%).

FSP re-entry: Of these **592** older adult FSP enrollments, 22 returned to an FSP program after discharging less than a year previously. These consumers are considered to have re-established partnership with 1 client re-establishing partnership more than once over his/her total time in partnership. The number of consumers that returned to an FSP program after more than a year had passed since discharging from an FSP program was 34.

| Older Adult Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| Under 90 days | 42 | 36 | 78 | 13% |
| >= 90 days and < 1 Year | 59 | 96 | 155 | 26% |
| >= 1 Year and < 2 Years | 21 | 72 | 93 | 16% |
| >= 2 Years and <3 Years | 31 | 48 | 79 | 13% |
| >= 3 Years and < 4 Years | 7 | 86 | 93 | 16% |
| >= 4 Years and < 5 years | 8 | 48 | 56 | 9% |
| >=5 Years and < 6 years | 3 | 5 | 8 | 1% |
| >=6 Years+ | 4 | 26 | 30 | 5% |
| **Total Consumer Enrollments** | **175** | **417** | **592** | |

| | | | |
|---|---|---|---|
| **Average Years in Partnership** | 3.13 | 7.63 | 2.28 |
| **Median Years in Partnership** | 0.69 | 2.15 | 1.70 |
| **Maximum Years in Partnership** | 13.35 | 11.63 | 13.35 |

Length of stay for consumers enrolled in each program is described on the following pages. The length of stay in a program includes only time enrolled in that specific program. Some consumers were enrolled in more than one program during FY 2023/2024 fiscal year or left and returned within the same fiscal year.

*Note: Active cases include those with an open episode in an older adult FSP reporting unit as of 6/30/2024. Closed cases include only those that do not have an open episode in an FSP reporting unit as of 6/30/2024. While some consumers leave partnership and later reestablish partnership in the same or different FSP program, time spent inactive is not included in this report.*

## Reason for Discontinuance of FSP: All Older Adults

Upon termination of FSP partnership a reason for discontinuance is selected. For recorded cases, the most common reasons for discontinuance were 'Partner left program' (27%), followed by 'Met goals' (22%) and 'Partner cannot be located' (22%). If a consumer terminated partnership more than once, each instance was recorded in this table.

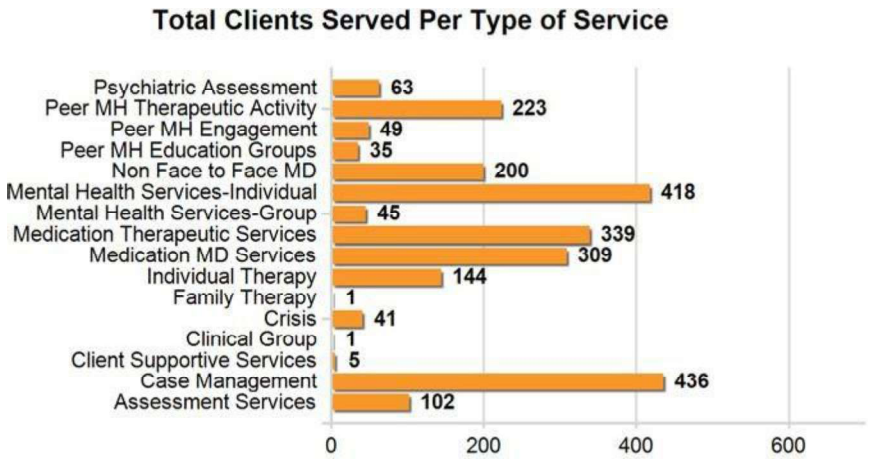
| Discontinuation Reason | Count | % |
|---|---|---|
| **Partner left program** | 35 | 27% |
| **Met goals** | 28 | 22% |
| **Partner cannot be located** | 28 | 22% |
| **Moved out of county/area** | 20 | 16% |
| **Deceased** | 8 | 6% |
| **Needs residential care** | 6 | 5% |
| **Target criteria not met** | 4 | 3% |
| **Total** | **129** | **100%** |

## Service Frequency By Month

The table below shows the number of individuals receiving various amounts of services per month, for each of month of the 2023/2024 fiscal year. The majority of consumers received either 4-7, or 8 or more services per month within the fiscal year. On average, more than 23% of older adult FSP consumers received 8 or more services per month.

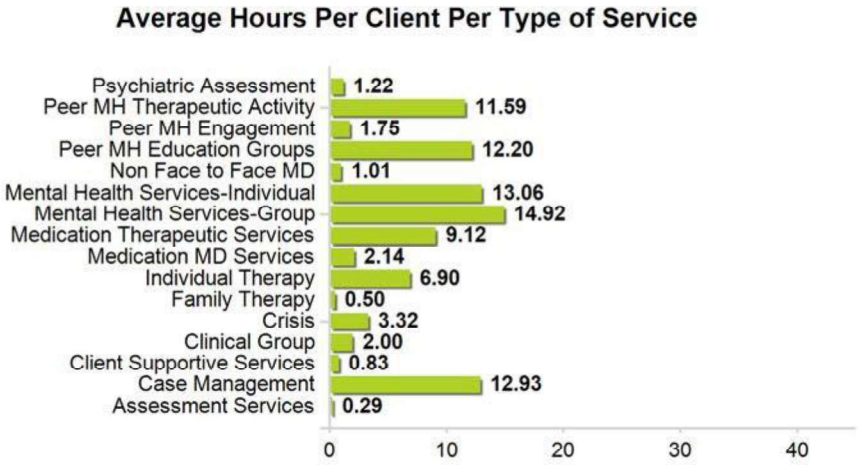
| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 55 (18%) | 60 (18%) | 62 (19%) | 58 (19%) | 54 (18%) | 70 (23%) | 62 (20%) | 69 (21%) | 69 (19%) | 78 (22%) | 64 (17%) | 59 (17%) |
| 2-3 | 81 (26%) | 77 (23%) | 93 (29%) | 92 (29%) | 93 (30%) | 92 (30%) | 87 (28%) | 92 (28%) | 111 (31%) | 70 (19%) | 79 (22%) | 84 (25%) |
| 4-7 | 96 (31%) | 92 (27%) | 109 (34%) | 96 (31%) | 97 (32%) | 95 (31%) | 84 (27%) | 101 (31%) | 113 (32%) | 127 (35%) | 116 (32%) | 117 (35%) |
| 8-13 | 61 (19%) | 71 (21%) | 39 (12%) | 50 (16%) | 43 (14%) | 41 (13%) | 45 (15%) | 55 (17%) | 45 (13%) | 61 (17%) | 71 (19%) | 53 (16%) |
| 14-19 | 15 (5%) | 23 (7%) | 12 (4%) | 12 (4%) | 16 (5%) | 7 (2%) | 25 (8%) | 10 (3%) | 12 (3%) | 14 (4%) | 24 (7%) | 11 (3%) |
| 20-25 | 5 (2%) | 8 (2%) | 2 (1%) | 4 (1%) | 1 (0%) | 3 (1%) | 4 (1%) | 1 (0%) | 4 (1%) | 6 (2%) | 5 (1%) | 12 (4%) |
| 26-31 | 0 (0%) | 3 (1%) | 2 (1%) | 1 (0%) | 1 (0%) | 2 (1%) | 2 (1%) | 1 (0%) | 2 (1%) | 1 (0%) | 3 (1%) | 2 (1%) |
| 32+ | 1 (0%) | 1 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 2 (1%) | 0 (0%) | 2 (1%) | 4 (1%) | 1 (0%) |
| Monthly Total | 314 | 335 | 319 | 313 | 305 | 310 | 309 | 331 | 356 | 359 | 366 | 339 |

## Service Detail




During the 2023/2024 Fiscal year, the top three services clients received were Case Management, Mental Health Services-Individual, and Medication Therapeutic Services.

The average number of hours consumers received of each type of service while in an older adult FSP program during the 2023/2024 fiscal year was calculated. As shown to the right, the average number of hours per consumer was highest in MH Services-Group (14.92 hours).

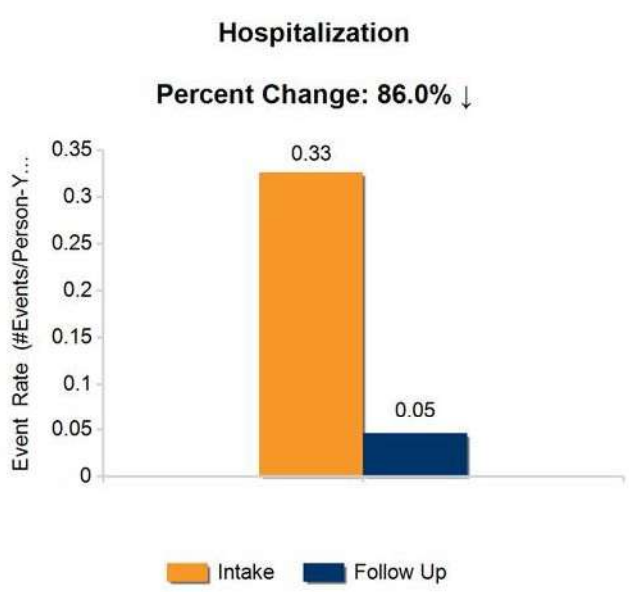



| Type of Service | # of OA | % of OA | # of Svcs | Avg. # Svcs |
|---|---|---|---|---|
| Assessment Services | 102 | 17% | 117 | 1.15 |
| Case Management | 436 | 74% | 6,125 | 14.05 |
| Client Supportive Services | 5 | 1% | 6 | 1.20 |
| Clinical Group | 1 | 0% | 1 | 1.00 |
| Crisis | 41 | 7% | 73 | 1.78 |
| Family Therapy | 1 | 0% | 1 | 1.00 |
| Individual Therapy | 144 | 24% | 1,068 | 7.42 |
| Medication MD Services | 309 | 52% | 953 | 3.08 |
| Medication Therapeutic Services | 339 | 57% | 3,577 | 10.55 |
| Mental Health Services-Group | 45 | 8% | 334 | 7.42 |
| Mental Health Services-Individual | 418 | 71% | 5,663 | 13.55 |
| Non Face to Face MD | 200 | 34% | 502 | 2.51 |
| Peer MH Education Groups | 35 | 6% | 181 | 5.17 |
| Peer MH Engagement | 49 | 8% | 95 | 1.94 |
| Peer MH Therapeutic Activity | 223 | 38% | 2,380 | 10.67 |
| Psychiatric Assessment | 63 | 11% | 64 | 1.02 |

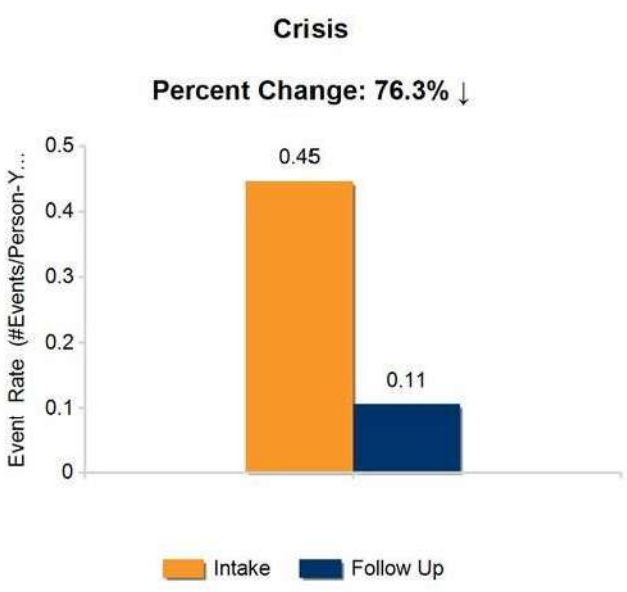
## Outcomes

Primary outcomes of interest for FSP include arrests, physical and mental health emergency room visits, incidences of acute hospitalizations and long-term care. The number of events in the 12 months prior to FSP enrollment are compared with the rate of 'number of events per person-year' in the program (i.e., follow-up). At follow-up, the number of outcome events occurring while enrolled were summed and divided by the number of years all individuals had been in the program. Actual counts for each outcome overall and by program can be found after page 11.

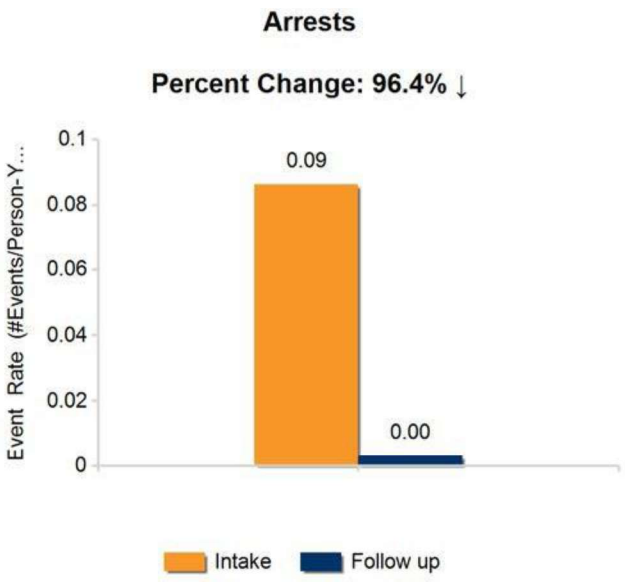
Overall, psychatric hospitalizations, use of mental health crisis facilities, arrests, and physical health emergencies reduced.



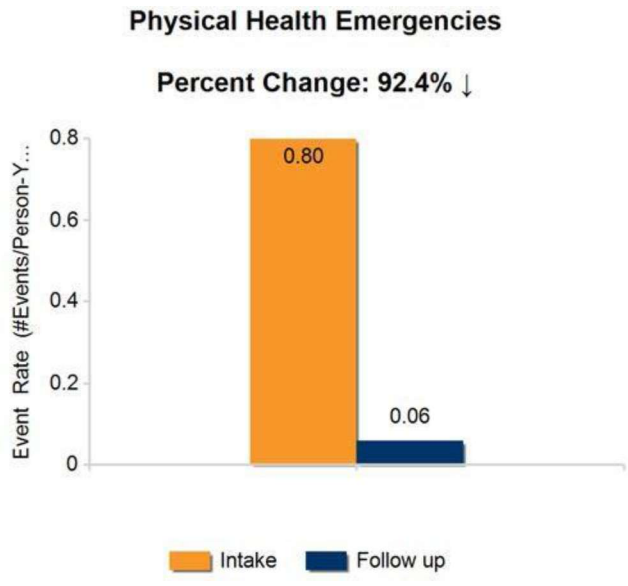

Hospitalizations decreased 86.0% from intake to follow-up.




Crisis decreased 76.3% from intake to follow-up.



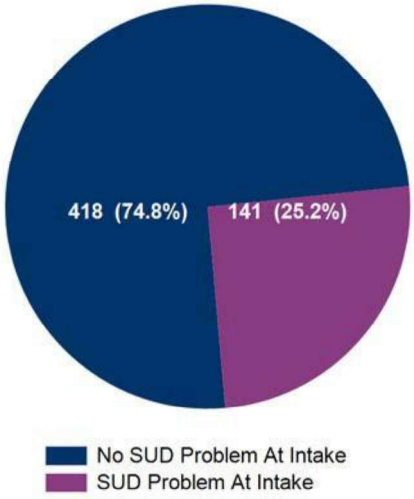

Arrests decreased 96.4% from intake to follow-up.

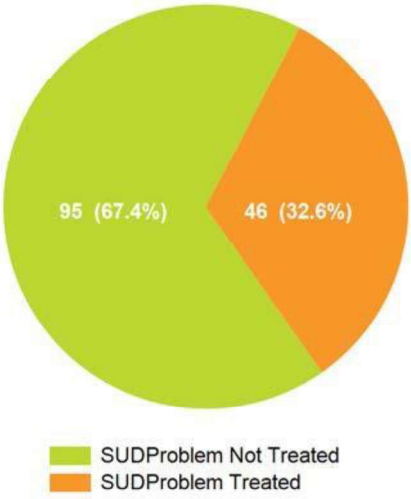



Physical Health Emergency visits decreased 92.4%.

## Outcomes: Substance Use

Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (25.2%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

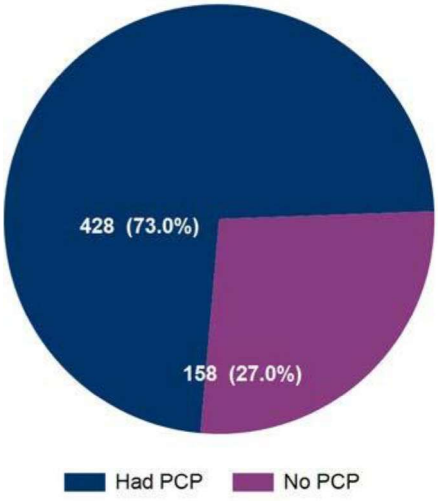



Follow-up: Based on follow-up data reported quarterly, 28.4% (27) of the 95 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 55 consumers not identified at intake were noted to have an SU problem on follow-up and 58.2% of them were reported to be in SU services on follow-up.

## Outcomes: Primary Care Physician

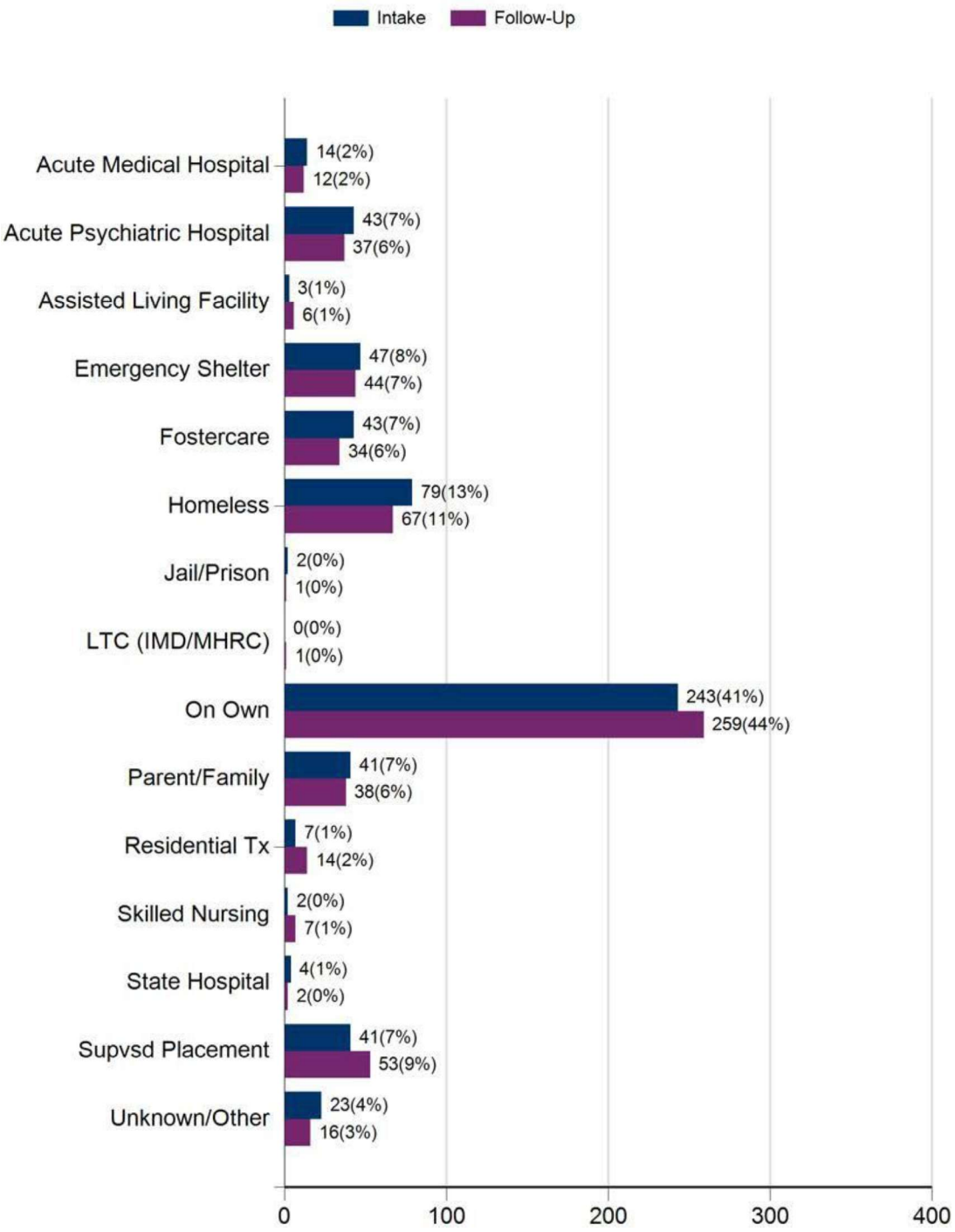
Intake: A little over a quarter of older adults (27.0%) did not have a primary care physician (PCP) at intake.




Follow-up: Of the 158 consumers that did not have a PCP at intake, 88 (55.7%) obtained a PCP while in the program.

## Outcomes: Residential

Overall, the older adult FSP consumers had a decrease in the proportion homeless and an increase in the percentage of consumers living on their own. Residential settings was calculated using the residential category from intake to their latest residential status. The percentages below are for all reporting units.



## Outcomes: Residential Days

The following compares consumers' living arrangements in the year prior to FSP enrollment to their living arrangements while enrolled in the program. Specifically, the number of days spent in each setting in the year before enrollment is compared to the number of days spent annually in each setting during enrollment. The goal of this analysis is to determine whether days in more stable settings during FSP participation had increased and days in less stable settings had decreased.

Baseline data was obtained from consumers' Partnership Assessment Form which includes the number of days consumers spent in each residential setting during the 12 months immediately prior to enrollment. Note that this 12 months preceded their **first** enrollment to any FSP program.

The number of days the consumers spent in each setting while enrolled in an FSP program was tracked through enrollment changes and residence changes noted on Key Event Tracking (KET) forms. When consumers re-enter an FSP program after a lapse in enrollment, their living arrangement is often noted on a KET form or new PAF, but if not, it was considered unknown. To accurately compare a year of pre-enrollment with a year of post enrollment, data for residential days during enrollment has been annualized.

| | 12 Months Prior to Enrollment | | Annualized Days During Enrollment | | |
|---|---|---|---|---|---|
| **Living Situation** | **# of Days** | **Count (n)** | **# of Days** | **Count (n)** | **Percent change (%)** |
| Acute Medical Hospital | 911 | 39 | 1,398 | 64 | -53% |
| Acute Psychiatric Hospital | 670 | 82 | 4,812 | 46 | -618% |
| Assisted Living Facility | 1,100 | 4 | 551 | 7 | 50% |
| Emergency Shelter | 11,904 | 67 | 12,140 | 57 | -2% |
| Homeless | 34,786 | 131 | 15,683 | 86 | 55% |
| Jail/Prison | 1,432 | 10 | 88 | 2 | 94% |
| LTC (IMD/MHRC) | 104 | 1 | - | 0 | 100% |
| On Own | 84,096 | 257 | 88,360 | 296 | -5% |
| Parent/Family | 15,348 | 51 | 15,043 | 45 | 2% |
| Residential Tx | 1,275 | 16 | 2,724 | 13 | -114% |
| Skilled Nursing | 49 | 2 | 901 | 10 | -1738% |
| State Hospital | 390 | 5 | 284 | 4 | 27% |
| Supervised Placement | 10,373 | 48 | 14,414 | 52 | -39% |
| Unknown/Other | 54,372 | 152 | 47,771 | 145 | 12% |

## FSP Older Adult demographics and Outcomes for: 33HJFO
## Served by this reporting unit: 124 Enrollment: 126

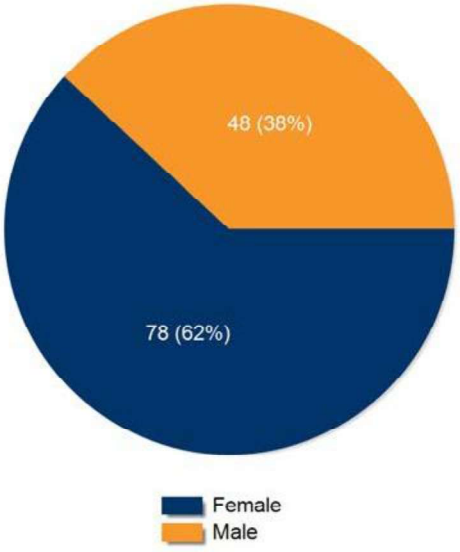
### Demographics

38% of consumers were male and 62% were female.

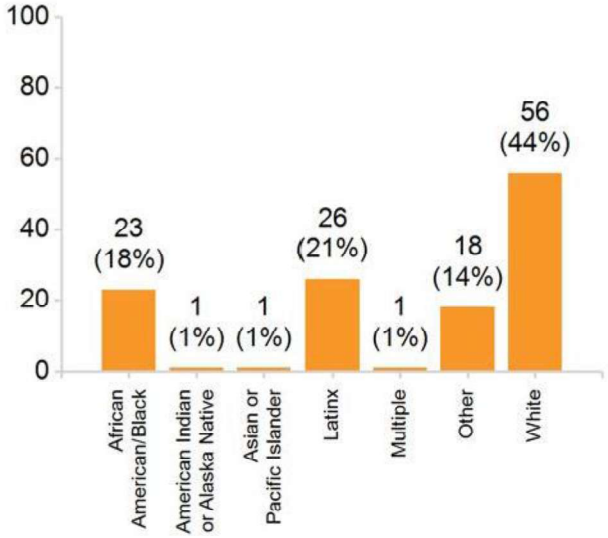
44% of consumers were White, 21% of consumers were Latinx and 18% of consumers were Black/African American.

83% of consumers were 60-69 years old.

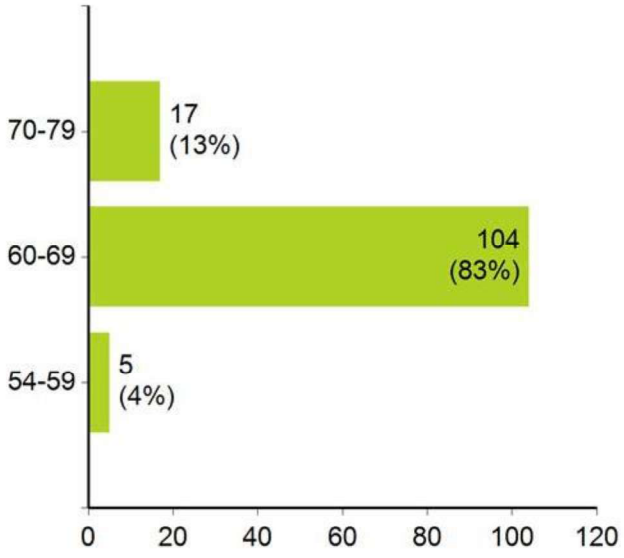
**Gender**




**Race/Ethnicity**




**Age**

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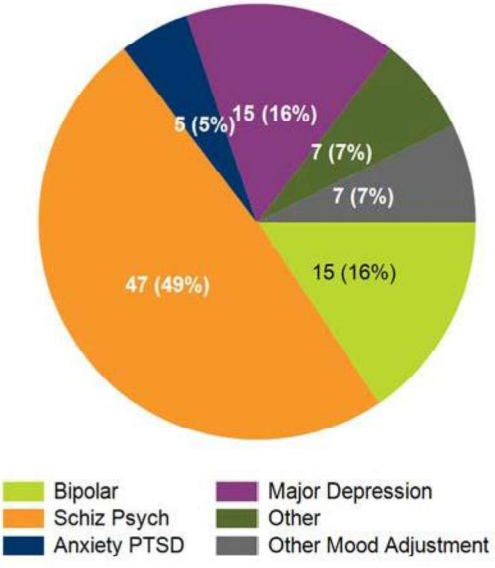
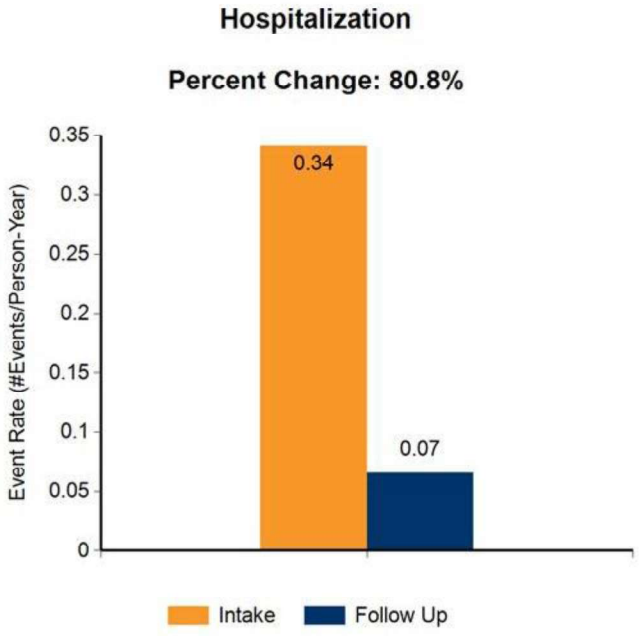
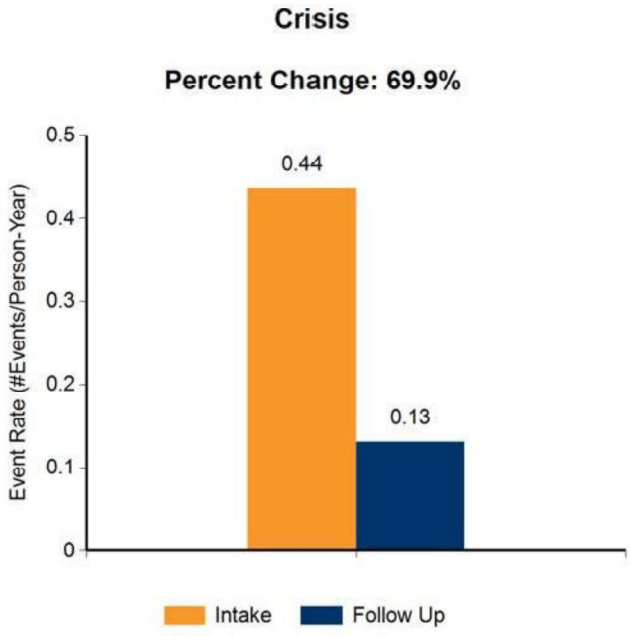
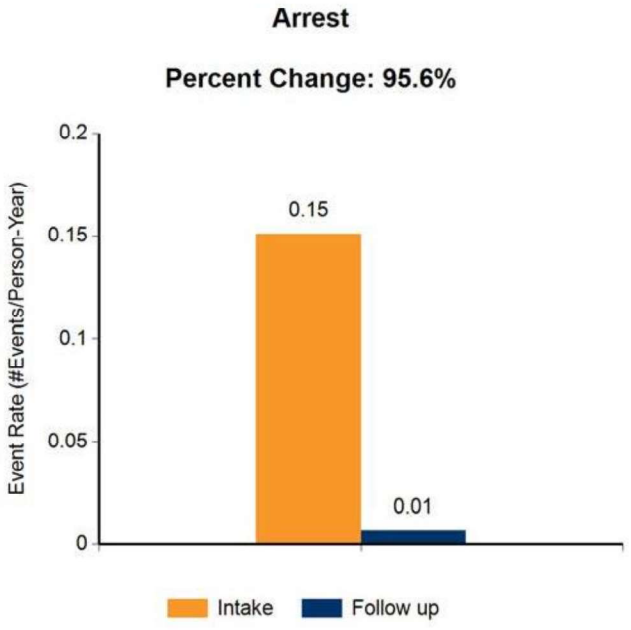


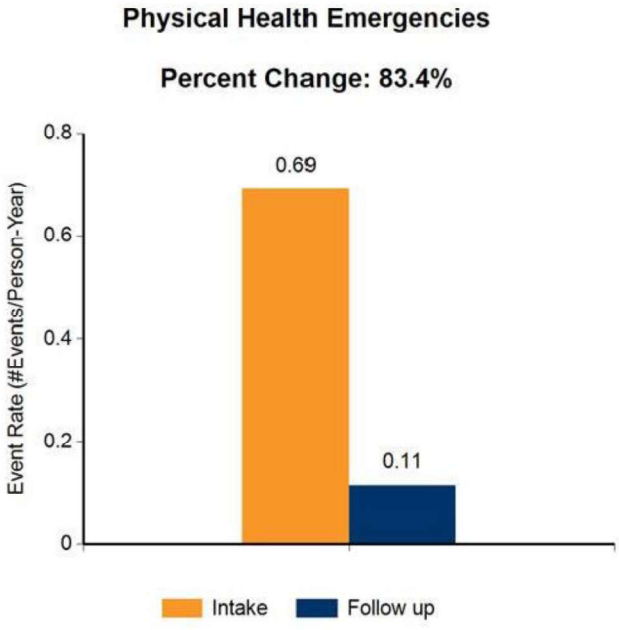
## Outcomes for 33HJFO

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

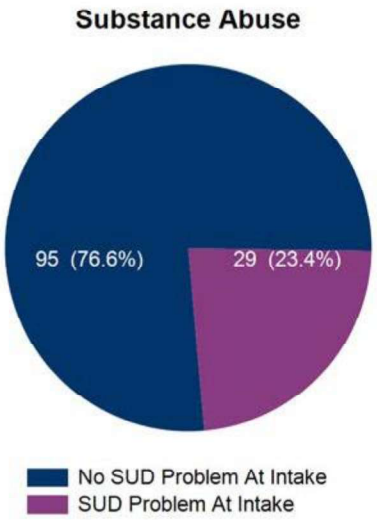


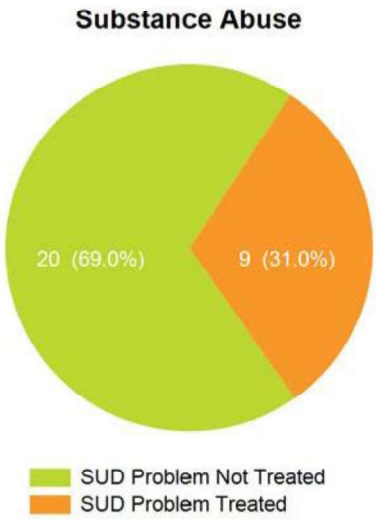



## Outcomes: Substance Use (33HJFO)

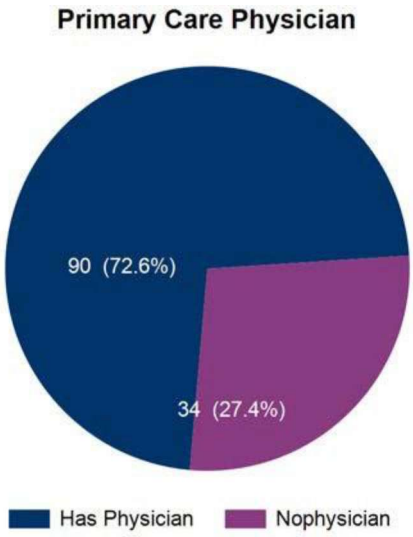



Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (23.4%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 20.0% (4) of the 20 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 13 consumers not identified at intake were noted to have an SU problem on follow-up and 20.0% of them were reported to be in SU services on follow-up.

## Outcomes: Primary Care Physician (33HJFO)




Intake: Most adults (72.6%) had a primary care physician (PCP) at intake.

Follow-up: Of the 34 consumers that did not have a PCP at intake, 20 (59.0%) obtained a PCP while in the program.

## FSP Older Adult demographics and Outcomes for: 33HKFO
## Served by this reporting unit: 101 Enrollment: 101

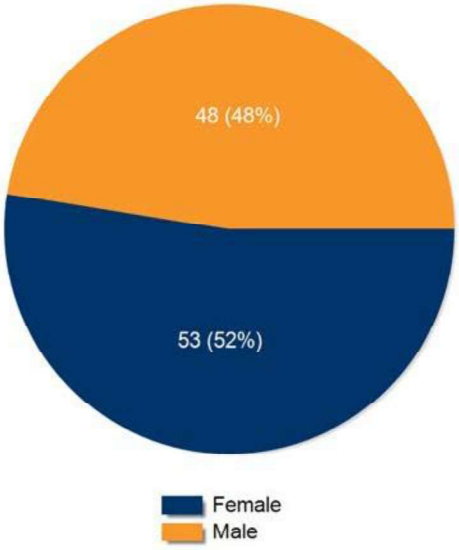
### Demographics

48% of consumers were male and 52% were female.

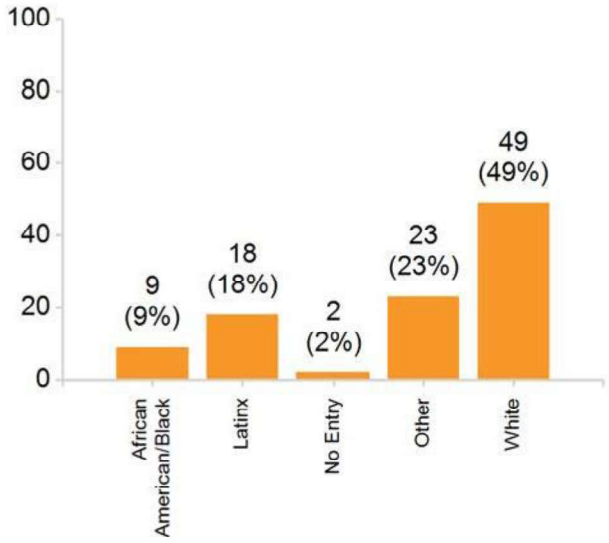
49% of consumers were White, 18% of consumers were Latinx and 9% of consumers were Black/African American.

75% of consumers were 60-69 years old.

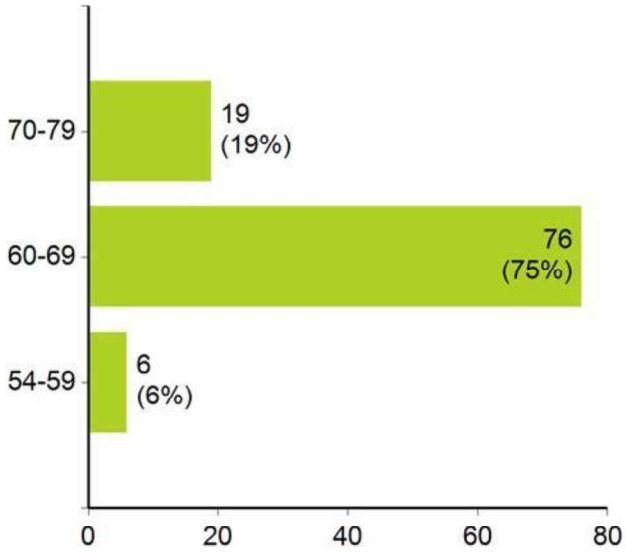
**Gender**



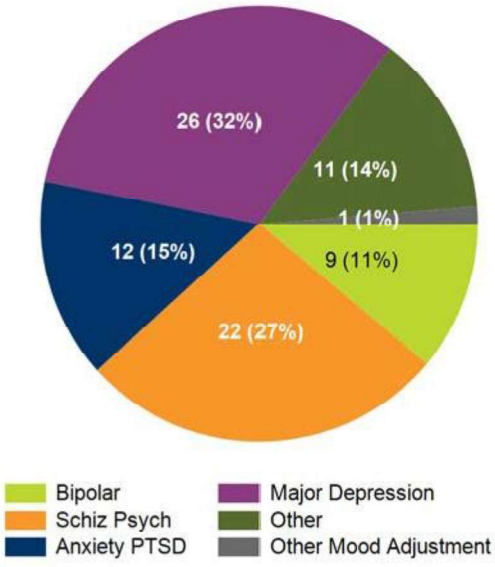

**Race/Ethnicity**




**Age**

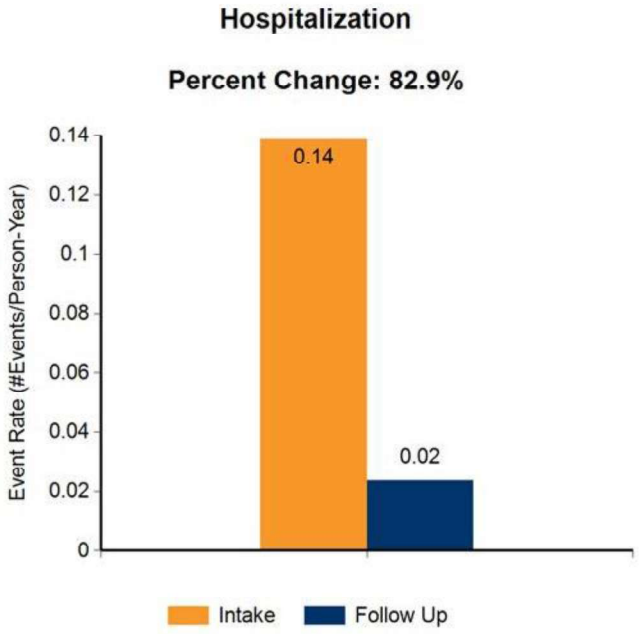


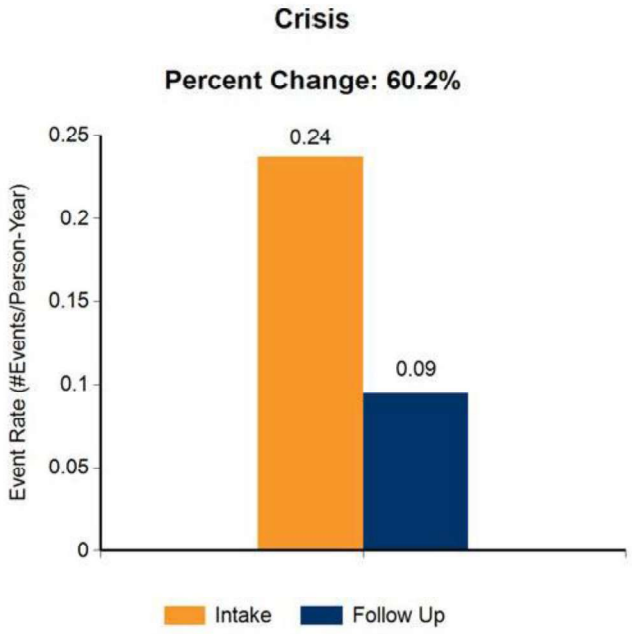

**Diagnosis**

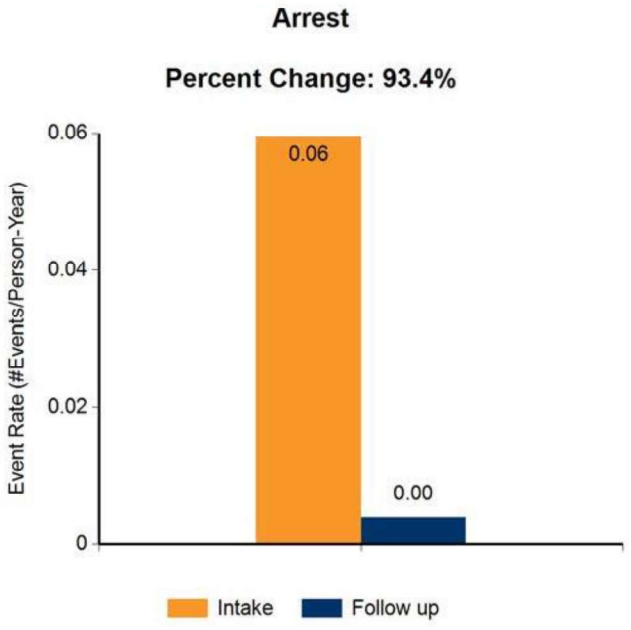


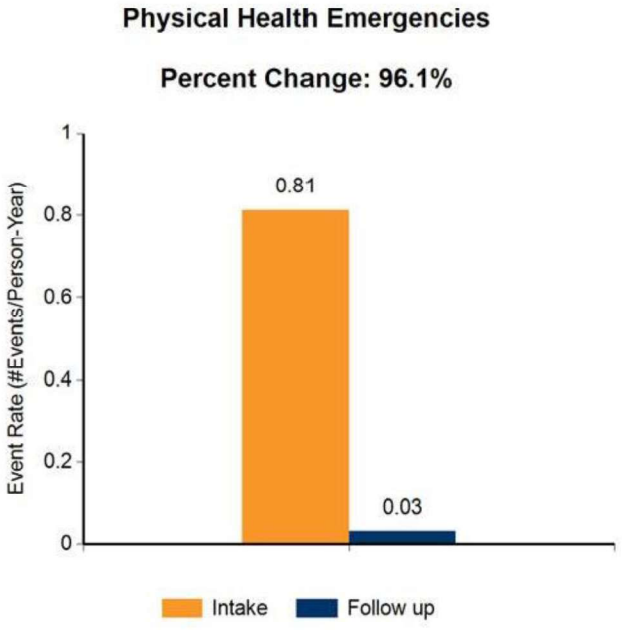
## Outcomes for 33HKFO

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

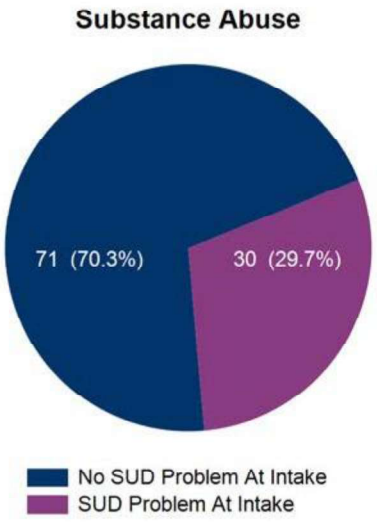


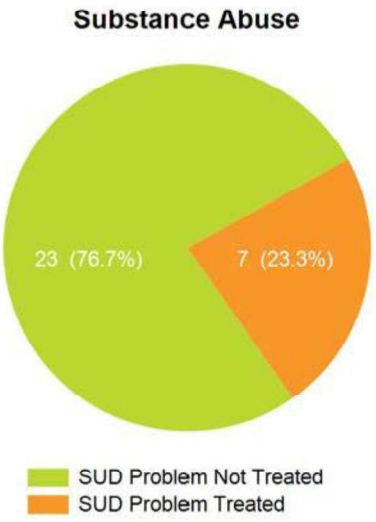



## Outcomes: Substance Use (33HKFO)

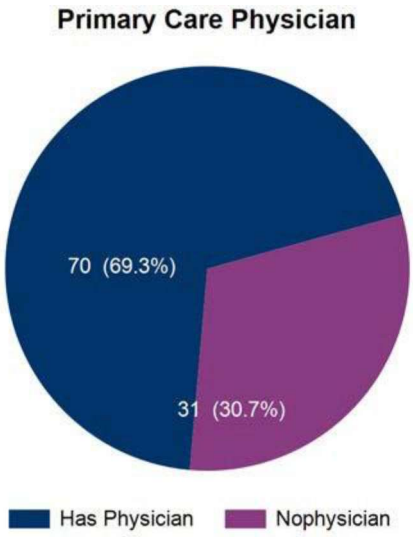



Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (29.7%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 13.0% (3) of the 23 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 10 consumers not identified at intake were noted to have an SU problem on follow-up and 13.0% of them were reported to be in SU services on follow-up.

## Outcomes: Primary Care Physician (33HKFO)




Intake: Most adults (69.3%) had a primary care physician (PCP) at intake.

Follow-up: Of the 31 consumers that did not have a PCP at intake, 23 (74.0%) obtained a PCP while in the program.

## FSP Older Adult demographics and Outcomes for: 33IJFO
## Served by this reporting unit: 213 Enrollment: 216

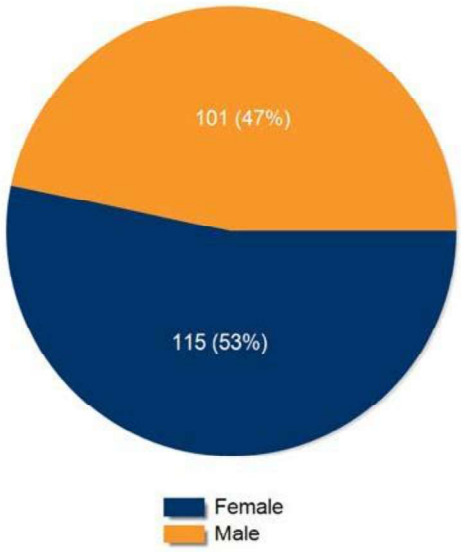
### Demographics

47% of consumers were male and 53% were female.

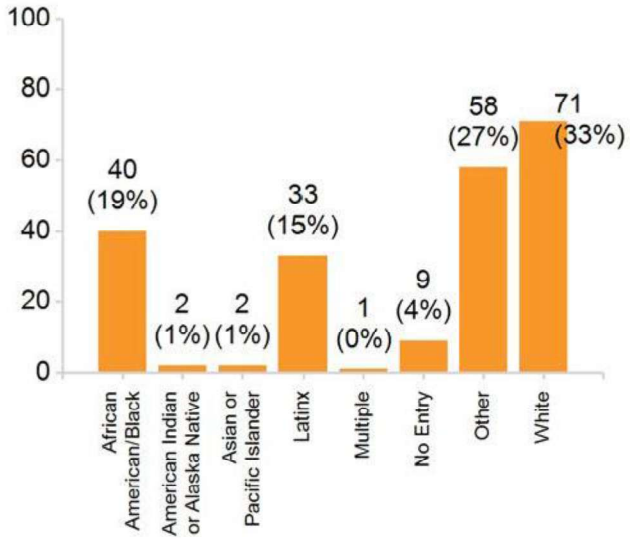
33% of consumers were White, 15% of consumers were Latinx and 19% of consumers were Black/African American.

83% of consumers were 60-69 years old.

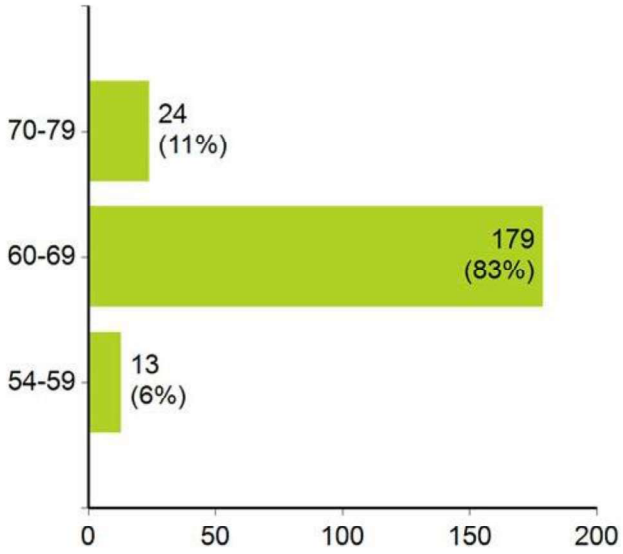
**Gender**



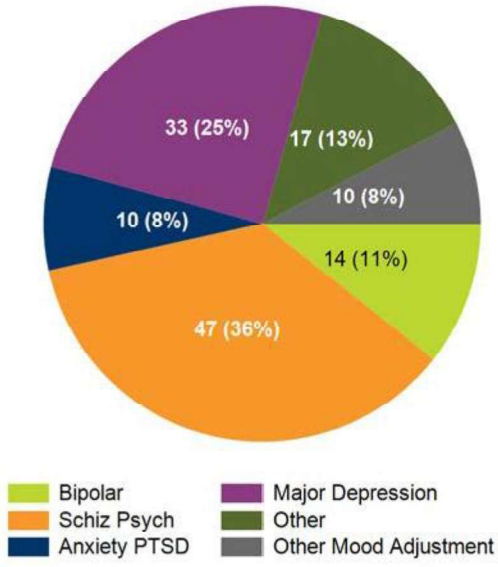

**Race/Ethnicity**




**Age**

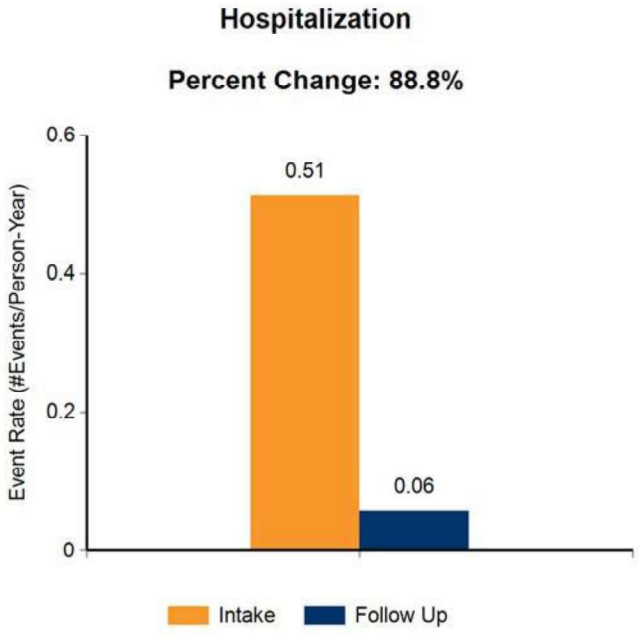


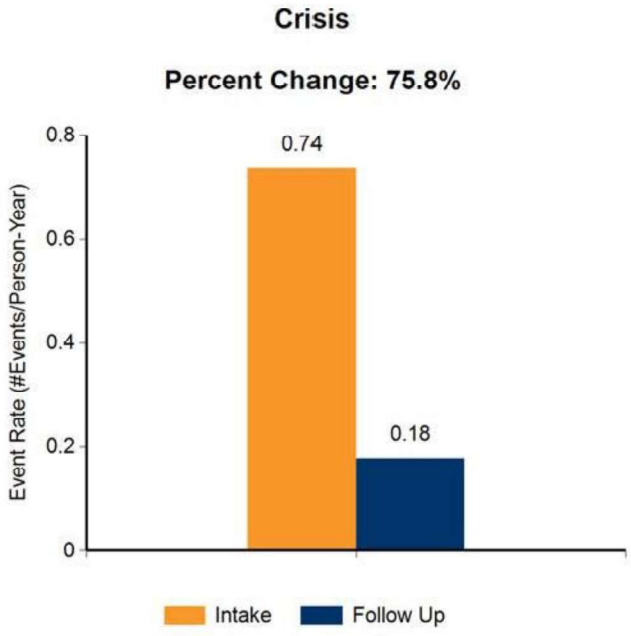

**Diagnosis**

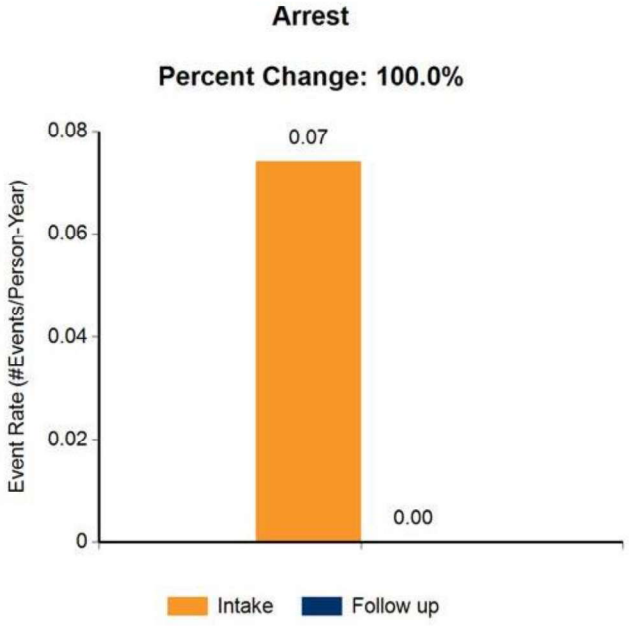


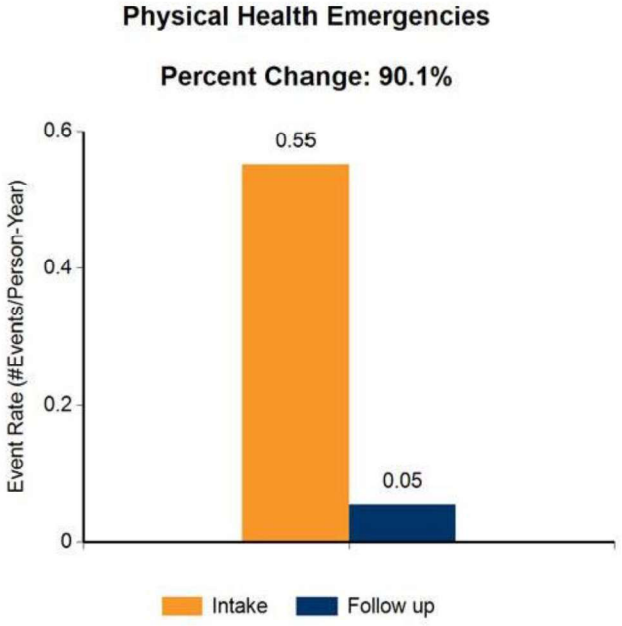
## Outcomes for 33IJFO

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

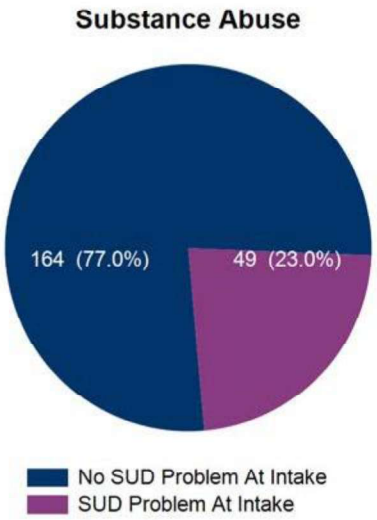


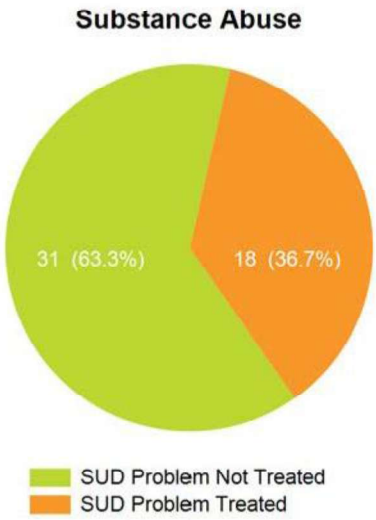



## Outcomes: Substance Use (33IJFO)

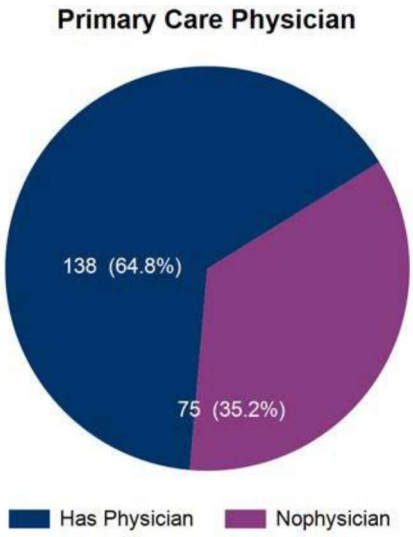



Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (23.0%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 38.7% (12) of the 31 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 13 consumers not identified at intake were noted to have an SU problem on follow-up and 39.0% of them were reported to be in SU services on follow-up.

## Outcomes: Primary Care Physician (33IJFO)




Intake: Most adults (64.8%) had a primary care physician (PCP) at intake.

Follow-up: Of the 75 consumers that did not have a PCP at intake, 38 (51.0%) obtained a PCP while in the program.

## FSP Older Adult demographics and Outcomes for: 33MTFO
## Served by this reporting unit: 148 Enrollment: 149

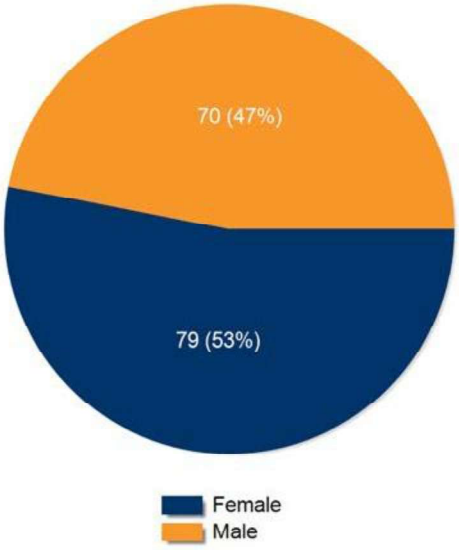
### Demographics

47% of consumers were male and 53% were female.

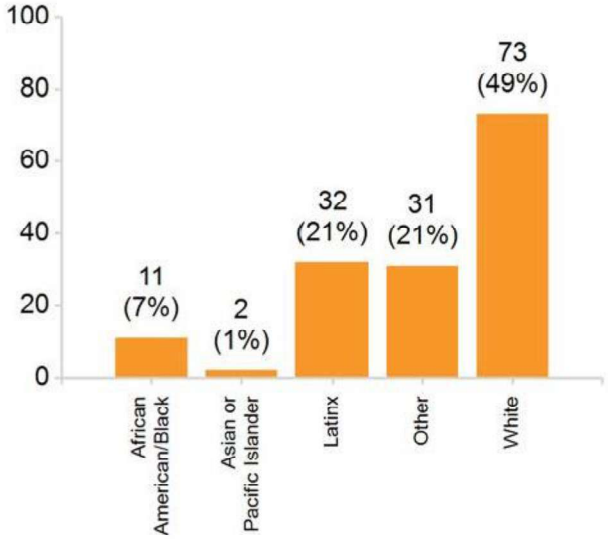
49% of consumers were White, 21% of consumers were Latinx and 7% of consumers were Black/African American.

76% of consumers were 60-69 years old.

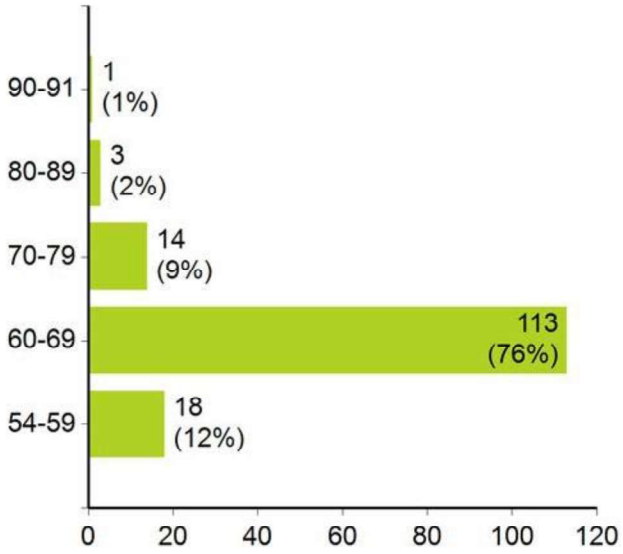
**Gender**



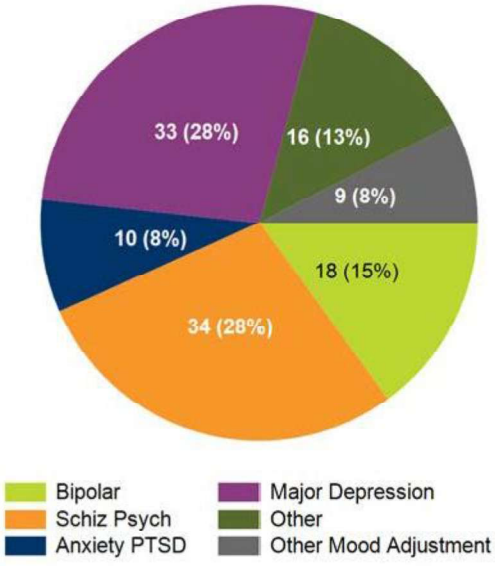

**Race/Ethnicity**




**Age**

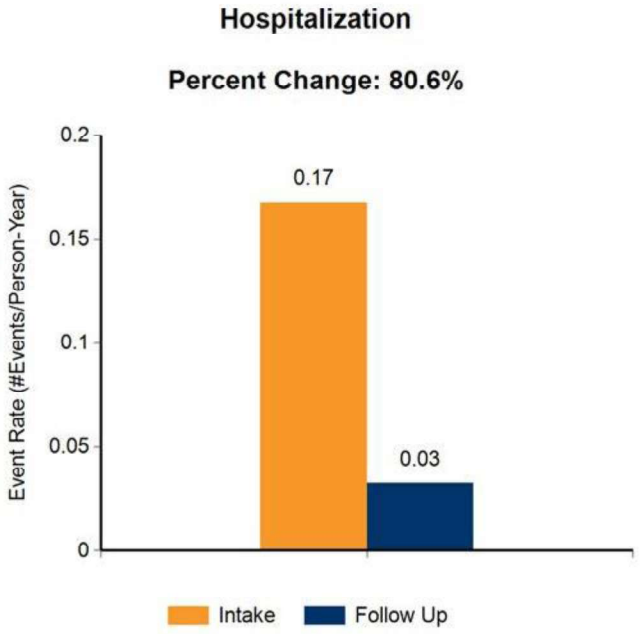


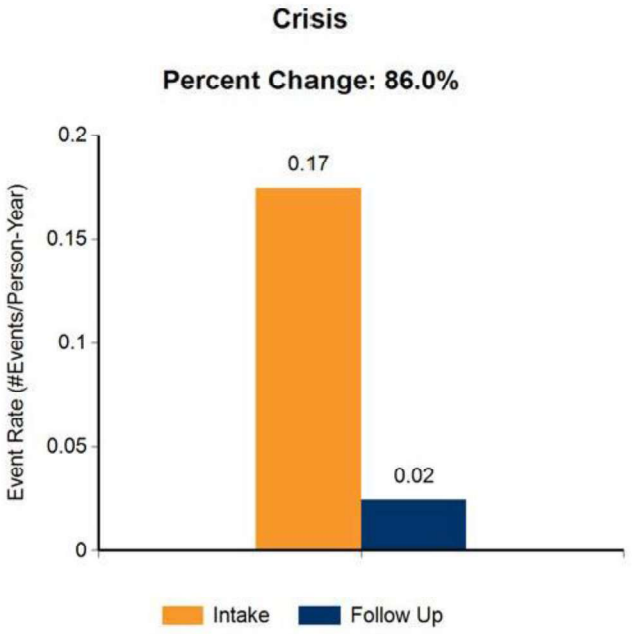

**Diagnosis**

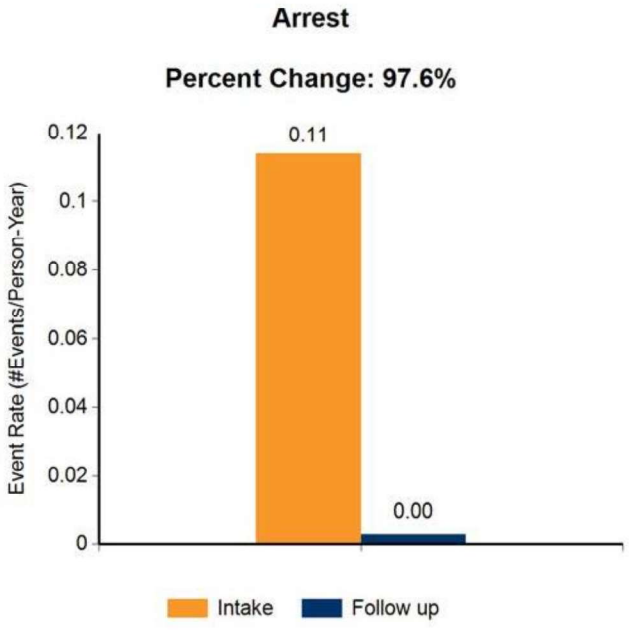


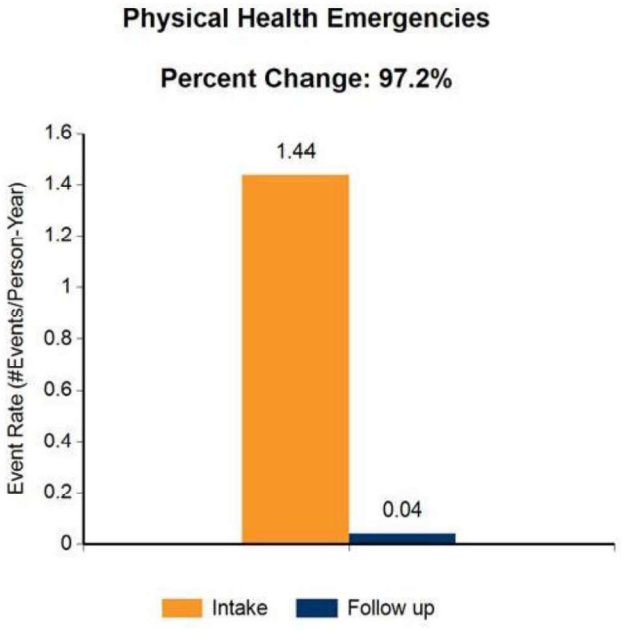
## Outcomes for 33MTFO

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

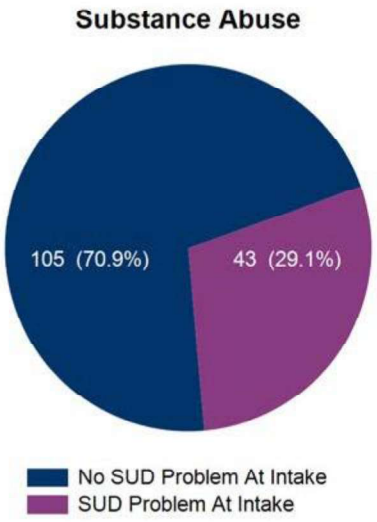


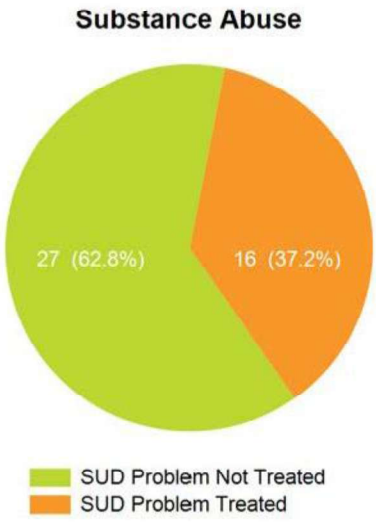



## Outcomes: Substance Use (33MTFO)

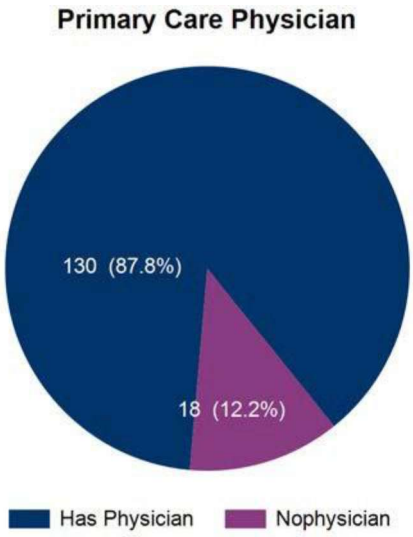



Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (29.1%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 29.6% (8) of the 27 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 17 consumers not identified at intake were noted to have an SU problem on follow-up and 30.0% of them were reported to be in SU services on follow-up.

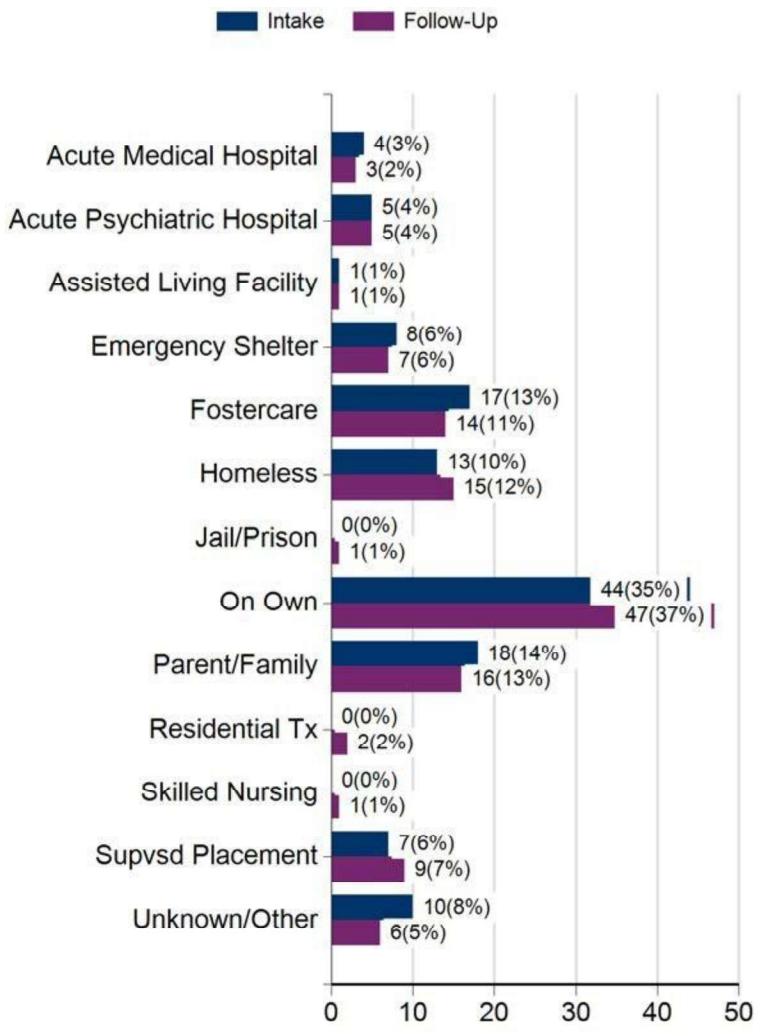
## Outcomes: Primary Care Physician (33MTFO)




Intake: Most adults (87.8%) had a primary care physician (PCP) at intake.

Follow-up: Of the 18 consumers that did not have a PCP at intake, 16 (89.0%) obtained a PCP while in the program.

## Outcomes: Residential & Discontinuance (33HJFO)




| Discontinuation Reason | Count | % |
|---|---|---|
| Met goals | 12 | 48% |
| Partner cannot be located | 6 | 24% |
| Partner left program | 4 | 16% |
| Moved out of county/area | 2 | 8% |
| Needs residential care | 1 | 4% |
| Total | 25 | 100% |

## Length of FSP Partnership for: 33HJFO

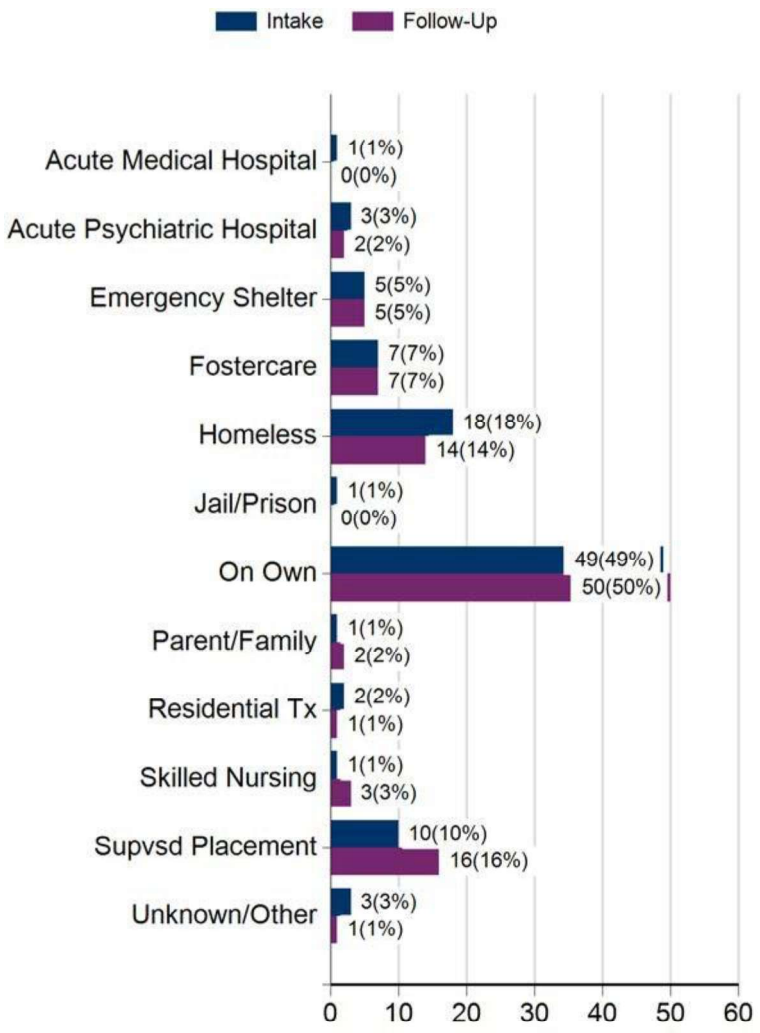
| OA Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| Under 90 days | 6 | 8 | 14 | 11.11% |
| >= 90 days and < 1 Year | 9 | 29 | 38 | 30.16% |
| >= 1 Year and < 2 Years | 0 | 13 | 13 | 10.32% |
| >= 2 Years and <3 Years | 8 | 12 | 20 | 15.87% |
| >= 3 Years and < 4 Years | 1 | 15 | 16 | 12.70% |
| >= 4 Years and < 5 years | 1 | 6 | 7 | 5.56% |
| >=5 Years and < 6 years | 2 | 1 | 3 | 2.38% |
| >=6 Years+ | 1 | 14 | 15 | 11.90% |
| Total Consumer Enrollments | 28 | 98 | 126 | |

## Service Detail: 33HJFO

| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 9 (15%) | 13 (19%) | 20 (33%) | 22 (33%) | 17 (25%) | 18 (25%) | 16 (27%) | 24 (32%) | 25 (30%) | 29 (33%) | 11 (13%) | 14 (18%) |
| 2-3 | 21 (34%) | 19 (27%) | 26 (43%) | 25 (37%) | 22 (33%) | 24 (33%) | 20 (33%) | 26 (35%) | 23 (27%) | 21 (24%) | 19 (23%) | 23 (29%) |
| 4-7 | 20 (33%) | 21 (30%) | 10 (17%) | 12 (18%) | 19 (28%) | 26 (36%) | 14 (23%) | 14 (19%) | 24 (29%) | 23 (26%) | 31 (37%) | 26 (33%) |
| 8-13 | 10 (16%) | 13 (19%) | 4 (7%) | 5 (7%) | 8 (12%) | 3 (4%) | 8 (13%) | 9 (12%) | 9 (11%) | 13 (15%) | 20 (24%) | 15 (19%) |
| 14-19 | 1 (2%) | 3 (4%) | 0 (0%) | 2 (3%) | 1 (1%) | 1 (1%) | 2 (3%) | 2 (3%) | 3 (4%) | 2 (2%) | 1 (1%) | 2 (3%) |
| 20-25 | 0 (0%) | 1 (1%) | 0 (0%) | 1 (1%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (1%) | 1 (1%) | 0 (0%) |
| Monthly Total | 61 | 70 | 60 | 67 | 67 | 72 | 60 | 75 | 84 | 89 | 83 | 80 |

| Type of Service | # of OA | % of OA | # of Svcs | Avg. # Svcs |
|---|---|---|---|---|
| Assessment Services | 13 | 3% | 13 | 1.00 |
| Case Management | 70 | 16% | 597 | 8.53 |
| Client Supportive Services | 1 | 0% | 1 | 1.00 |
| Crisis | 2 | 0% | 4 | 2.00 |
| Individual Therapy | 8 | 2% | 13 | 1.63 |
| Medication MD Services | 87 | 20% | 273 | 3.14 |
| Medication Therapeutic Services | 70 | 16% | 658 | 9.40 |
| Mental Health Services-Group | 2 | 0% | 22 | 11.00 |
| Mental Health Services-Individual | 103 | 23% | 1,325 | 12.86 |
| Non Face to Face MD | 46 | 10% | 95 | 2.07 |
| Peer MH Education Groups | 2 | 0% | 2 | 1.00 |
| Peer MH Engagement | 10 | 2% | 21 | 2.10 |
| Peer MH Therapeutic Activity | 31 | 7% | 597 | 19.26 |

## Outcomes: Residential & Discontinuance (33HKFO)




| Discontinuation Reason | Count | % |
|---|---|---|
| **Met goals** | 6 | 30% |
| **Deceased** | 5 | 25% |
| **Moved out of county/area** | 4 | 20% |
| **Partner cannot be located** | 2 | 10% |
| **Partner left program** | 2 | 10% |
| **Target criteria not met** | 1 | 5% |
| **Total** | **20** | **100%** |

## Length of FSP Partnership for: 33HKFO

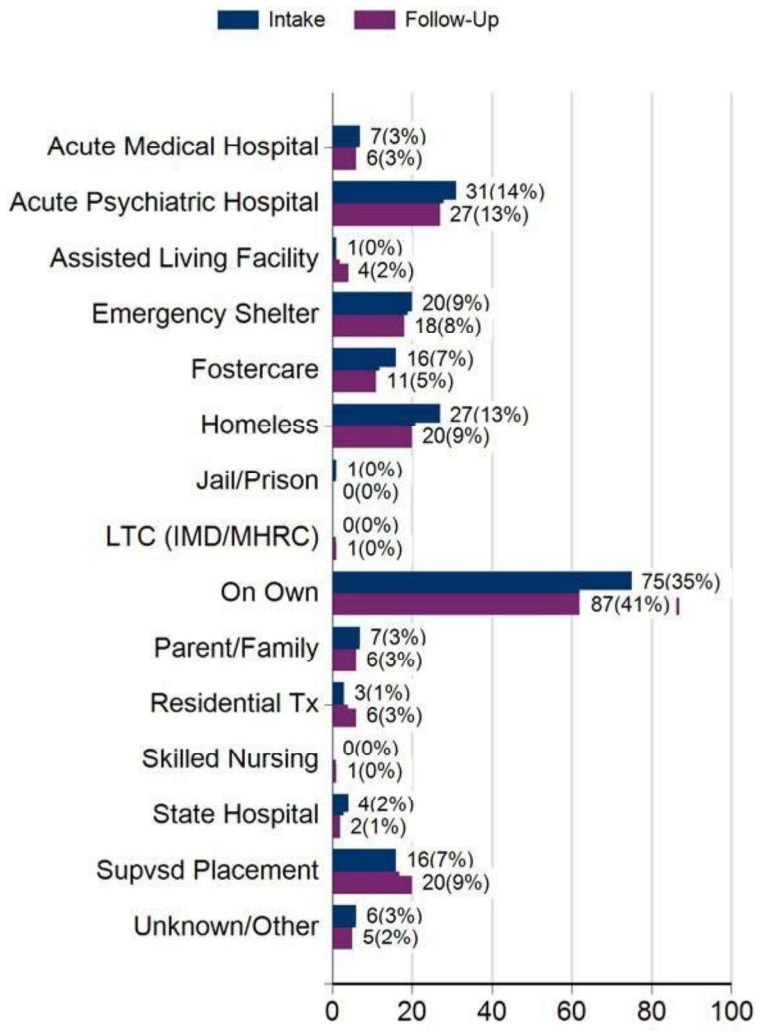
| OA Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| Under 90 days | 2 | 4 | 6 | 5.94% |
| >= 90 days and < 1 Year | 3 | 12 | 15 | 14.85% |
| >= 1 Year and < 2 Years | 4 | 14 | 18 | 17.82% |
| >= 2 Years and <3 Years | 10 | 11 | 21 | 20.79% |
| >= 3 Years and < 4 Years | 3 | 27 | 30 | 29.70% |
| >= 4 Years and < 5 years | 0 | 4 | 4 | 3.96% |
| >=5 Years and < 6 years | 1 | 1 | 2 | 1.98% |
| >=6 Years+ | 0 | 5 | 5 | 4.95% |
| **Total Consumer Enrollments** | **23** | **78** | **101** | |

## Service Detail: 33HKFO

| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 7 (9%) | 9 (12%) | 10 (13%) | 6 (8%) | 4 (6%) | 17 (22%) | 10 (14%) | 12 (17%) | 12 (15%) | 7 (9%) | 13 (15%) | 8 (10%) |
| 2-3 | 19 (24%) | 15 (19%) | 18 (23%) | 26 (34%) | 26 (38%) | 24 (32%) | 26 (37%) | 24 (33%) | 32 (40%) | 16 (21%) | 17 (20%) | 24 (30%) |
| 4-7 | 37 (46%) | 26 (34%) | 39 (50%) | 33 (43%) | 30 (44%) | 27 (36%) | 24 (34%) | 31 (43%) | 28 (35%) | 42 (54%) | 38 (45%) | 42 (53%) |
| 8-13 | 16 (20%) | 26 (34%) | 10 (13%) | 11 (14%) | 7 (10%) | 8 (11%) | 10 (14%) | 5 (7%) | 7 (9%) | 12 (15%) | 14 (17%) | 6 (8%) |
| 14-19 | 1 (1%) | 1 (1%) | 1 (1%) | 1 (1%) | 1 (1%) | 0 (0%) | 1 (1%) | 0 (0%) | 1 (1%) | 1 (1%) | 2 (2%) | 0 (0%) |
| Monthly Total | 80 | 77 | 78 | 77 | 68 | 76 | 71 | 72 | 80 | 78 | 84 | 80 |

| Type of Service | # of OA | % of OA | # of Svcs | Avg. # Svcs |
|---|---|---|---|---|
| Assessment Services | 6 | 1% | 6 | 1.00 |
| Case Management | 87 | 21% | 1,335 | 15.34 |
| Client Supportive Services | 2 | 0% | 3 | 1.50 |
| Clinical Group | 1 | 0% | 1 | 1.00 |
| Crisis | 5 | 1% | 6 | 1.20 |
| Family Therapy | 1 | 0% | 1 | 1.00 |
| Individual Therapy | 23 | 5% | 114 | 4.96 |
| Medication MD Services | 54 | 13% | 152 | 2.81 |
| Medication Therapeutic Services | 66 | 16% | 1,059 | 16.05 |
| Mental Health Services-Group | 10 | 2% | 110 | 11.00 |
| Mental Health Services-Individual | 79 | 19% | 1,156 | 14.63 |
| Non Face to Face MD | 54 | 13% | 192 | 3.56 |
| Peer MH Education Groups | 3 | 1% | 3 | 1.00 |
| Peer MH Engagement | 1 | 0% | 1 | 1.00 |
| Peer MH Therapeutic Activity | 24 | 6% | 121 | 5.04 |
| Psychiatric Assessment | 3 | 1% | 3 | 1.00 |

## Outcomes: Residential & Discontinuance (33IJFO)




| Discontinuation Reason | Count | % |
|---|---|---|
| Partner left program | 27 | 36% |
| Partner cannot be located | 19 | 25% |
| Moved out of county/area | 14 | 18% |
| Met goals | 8 | 11% |
| Needs residential care | 4 | 5% |
| Target criteria not met | 3 | 4% |
| Deceased | 1 | 1% |
| **Total** | **76** | **100%** |

## Length of FSP Partnership for: 33IJFO

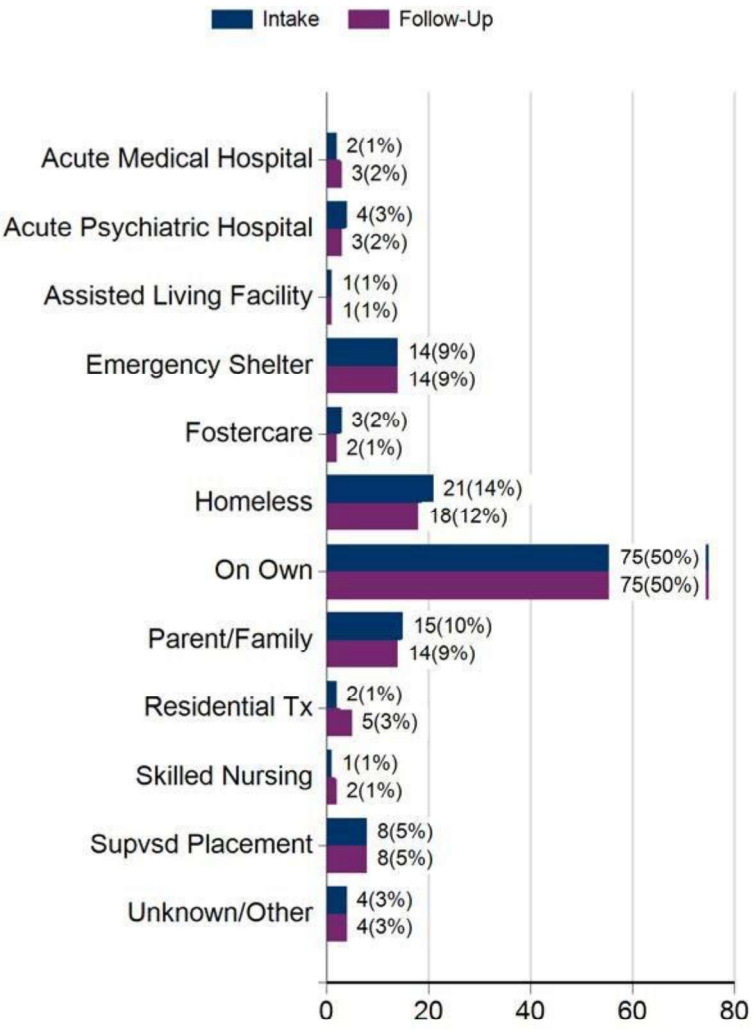
| OA Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| Under 90 days | 32 | 16 | 48 | 22.22% |
| >= 90 days and < 1 Year | 43 | 35 | 78 | 36.11% |
| >= 1 Year and < 2 Years | 14 | 21 | 35 | 16.20% |
| >= 2 Years and <3 Years | 9 | 5 | 14 | 6.48% |
| >= 3 Years and < 4 Years | 1 | 15 | 16 | 7.41% |
| >= 4 Years and < 5 years | 5 | 7 | 12 | 5.56% |
| >=5 Years and < 6 years | 0 | 3 | 3 | 1.39% |
| >=6 Years+ | 3 | 7 | 10 | 4.63% |
| **Total Consumer Enrollments** | **107** | **109** | **216** | |

## Service Detail: 33IJFO

| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 14 (15%) | 13 (13%) | 14 (14%) | 6 (7%) | 10 (11%) | 14 (16%) | 13 (15%) | 10 (11%) | 12 (11%) | 25 (23%) | 22 (20%) | 16 (16%) |
| 2-3 | 13 (14%) | 20 (20%) | 15 (15%) | 18 (20%) | 17 (18%) | 19 (21%) | 13 (15%) | 10 (11%) | 23 (22%) | 14 (13%) | 12 (11%) | 13 (13%) |
| 4-7 | 26 (27%) | 19 (19%) | 42 (43%) | 29 (32%) | 28 (30%) | 26 (29%) | 20 (22%) | 28 (31%) | 36 (34%) | 34 (31%) | 22 (20%) | 25 (25%) |
| 8-13 | 27 (28%) | 22 (22%) | 17 (18%) | 28 (31%) | 25 (27%) | 22 (25%) | 20 (22%) | 33 (37%) | 24 (23%) | 27 (24%) | 29 (26%) | 26 (26%) |
| 14-19 | 11 (12%) | 16 (16%) | 6 (6%) | 7 (8%) | 11 (12%) | 5 (6%) | 18 (20%) | 5 (6%) | 5 (5%) | 6 (5%) | 16 (14%) | 6 (6%) |
| 20-25 | 3 (3%) | 6 (6%) | 1 (1%) | 2 (2%) | 1 (1%) | 2 (2%) | 4 (4%) | 1 (1%) | 3 (3%) | 3 (3%) | 4 (4%) | 10 (10%) |
| 26-31 | 0 (0%) | 3 (3%) | 2 (2%) | 1 (1%) | 0 (0%) | 1 (1%) | 1 (1%) | 1 (1%) | 2 (2%) | 1 (1%) | 3 (3%) | 2 (2%) |
| 32+ | 1 (1%) | 1 (1%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (1%) | 0 (0%) | 1 (1%) | 3 (3%) | 1 (1%) |
| Monthly Total | 95 | 100 | 97 | 91 | 92 | 89 | 89 | 89 | 105 | 111 | 111 | 99 |

| Type of Service | # of OA | % of OA | # of Svcs | Avg. # Svcs |
|---|---|---|---|---|
| Assessment Services | 68 | 8% | 82 | 1.21 |
| Case Management | 191 | 21% | 3,358 | 17.58 |
| Client Supportive Services | 2 | 0% | 2 | 1.00 |
| Crisis | 20 | 2% | 39 | 1.95 |
| Individual Therapy | 64 | 7% | 562 | 8.78 |
| Medication MD Services | 71 | 8% | 186 | 2.62 |
| Medication Therapeutic Services | 89 | 10% | 717 | 8.06 |
| Mental Health Services-Group | 25 | 3% | 165 | 6.60 |
| Mental Health Services-Individual | 140 | 16% | 2,594 | 18.53 |
| Non Face to Face MD | 36 | 4% | 65 | 1.81 |
| Peer MH Education Groups | 24 | 3% | 88 | 3.67 |
| Peer MH Engagement | 7 | 1% | 8 | 1.14 |
| Peer MH Therapeutic Activity | 112 | 12% | 1,026 | 9.16 |
| Psychiatric Assessment | 52 | 6% | 52 | 1.00 |

## Outcomes: Residential & Discontinuance (33MTFO)




| Discontinuation Reason | Count | % |
|---|---|---|
| Deceased | 2 | 25% |
| Met goals | 2 | 25% |
| Partner left program | 2 | 25% |
| Needs residential care | 1 | 13% |
| Partner cannot be located | 1 | 13% |
| Total | 8 | 100% |

## Length of FSP Partnership for: 33MTFO

| OA Time in Partnership | Closed | Open | All Consumers | % of Total |
|---|---|---|---|---|
| Under 90 days | 2 | 8 | 10 | 6.71% |
| >= 90 days and < 1 Year | 4 | 20 | 24 | 16.11% |
| >= 1 Year and < 2 Years | 3 | 24 | 27 | 18.12% |
| >= 2 Years and <3 Years | 4 | 20 | 24 | 16.11% |
| >= 3 Years and < 4 Years | 2 | 29 | 31 | 20.81% |
| >= 4 Years and < 5 years | 2 | 31 | 33 | 22.15% |
| Total Consumer Enrollments | 17 | 132 | 149 | |

## Service Detail: 33MTFO

| Service Frequencies | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-1 | 25 (32%) | 25 (28%) | 18 (21%) | 24 (31%) | 23 (29%) | 21 (29%) | 23 (26%) | 23 (24%) | 20 (23%) | 17 (21%) | 18 (20%) | 21 (26%) |
| 2-3 | 28 (36%) | 23 (26%) | 34 (40%) | 23 (29%) | 28 (36%) | 25 (34%) | 28 (31%) | 32 (34%) | 33 (38%) | 19 (23%) | 31 (35%) | 24 (30%) |
| 4-7 | 13 (17%) | 26 (30%) | 18 (21%) | 22 (28%) | 20 (26%) | 16 (22%) | 26 (29%) | 28 (29%) | 25 (29%) | 28 (35%) | 25 (28%) | 24 (30%) |
| 8-13 | 8 (10%) | 10 (11%) | 8 (10%) | 6 (8%) | 3 (4%) | 8 (11%) | 7 (8%) | 8 (8%) | 5 (6%) | 9 (11%) | 8 (9%) | 6 (8%) |
| 14-19 | 2 (3%) | 3 (3%) | 5 (6%) | 2 (3%) | 3 (4%) | 1 (1%) | 4 (4%) | 3 (3%) | 3 (3%) | 5 (6%) | 5 (6%) | 3 (4%) |
| 20-25 | 2 (3%) | 1 (1%) | 1 (1%) | 1 (1%) | 0 (0%) | 1 (1%) | 0 (0%) | 0 (0%) | 1 (1%) | 2 (2%) | 0 (0%) | 2 (3%) |
| 26-31 | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (1%) | 1 (1%) | 1 (1%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| 32+ | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (1%) | 0 (0%) | 1 (1%) | 1 (1%) | 0 (0%) |
| Monthly Total | 78 | 88 | 84 | 78 | 78 | 73 | 89 | 95 | 87 | 81 | 88 | 80 |

| Type of Service | # of OA | % of OA | # of Svcs | Avg. # Svcs |
|---|---|---|---|---|
| Assessment Services | 15 | 2% | 16 | 1.07 |
| Case Management | 88 | 14% | 835 | 9.49 |
| Crisis | 14 | 2% | 24 | 1.71 |
| Individual Therapy | 49 | 8% | 379 | 7.73 |
| Medication MD Services | 97 | 15% | 342 | 3.53 |
| Medication Therapeutic Services | 114 | 18% | 1,143 | 10.03 |
| Mental Health Services-Group | 8 | 1% | 37 | 4.63 |
| Mental Health Services-Individual | 96 | 15% | 588 | 6.13 |
| Non Face to Face MD | 64 | 10% | 150 | 2.34 |
| Peer MH Education Groups | 6 | 1% | 88 | 14.67 |
| Peer MH Engagement | 31 | 5% | 65 | 2.10 |
| Peer MH Therapeutic Activity | 56 | 9% | 636 | 11.36 |
| Psychiatric Assessment | 8 | 1% | 9 | 1.13 |

# CSS-02 General System Development (GSD)

**What is GSD?**

The expansion or enhancement of the public mental health services system to meet specialized service goals or to increase the number of people served. GSD is the development and operation of programs that provide mental health services to:

1) Children and TAY who experience severe emotional or behavioral challenges.
2) Adults and Older Adults who carry a serious mental health diagnosis.
3) Adults or Older Adults who require or are at risk of requiring acute psychiatric hospitalization, residential treatment, or outpatient crisis intervention because of a serious mental health diagnosis.

## *GSD: Clinic Expansion*

## *GSD: Clinic Expansion/Enhancements: Youth System of Care*

The expansion of clinic staff to include Parent Partners and Peer Support Specialists as part of the clinical team has become a standard of care in RUHS-BH service delivery. Though our Lived Experience Programs have essential roles in Outreach and Engagement, they are also integral to general clinic operations.

Parent Partners welcome new families to the mental health system through an orientation process that informs parents about clinic services and offers support/advocacy in a welcoming setting. Parent Partners are advocates assisting with system navigation and education. Parent Partner services are invaluable in promoting engagement from the first family contact, providing support and education to families, and supporting the parent's voice and full involvement in all aspects of their child's service planning and provision of services. Parent Partners provide parenting training such as Nurturing Parenting, Triple P and Triple P Teen, EES (Educate, Equip, Support), the parent portion of IY Dinosaur School, and recently added the Nurturing Father's Program.

Transition-age youth (TAY) Peer Support Specialists also bring the lived experience of behavioral health challenges as young adults. TAY Peers can engage youth and provide supportive services such as rehabilitative services and in-home Behavioral Services.

Children's Integrated Service programs served 10,083 (7,259 youth; 2,824 parents and community members) in FY23/24. Across the entire Children's Work Plan, the demographic profile of youth served was 58% Hispanic/Latino, 10% Black /African American, and 14% White. A large proportion (16%) of youth served were reported as "Other" race/ethnicity. Asian/Pacific Islander youth represented 1%, and Multiracial represented 1% of the youth served. Children's clinics use the Child Adolescent Needs and Strengths measure as required by the state to monitor children's outcomes. Overall, CAN scores showed improvements for children/youth; 53% of children's Behavioral/Emotional Health needs Improved. This includes

children with initial scores reflecting a moderate degree of need (action intervention required) or severe (immediate action intervention required). Life Domain Functioning Improved by 48%, and 41 % increased in the Strengths domain.

Systems development service enhancements, interagency collaboration, and the expansion of effective evidence-based models continue to be central components of the Children's Work Plan.

Team Decision Making (TDM) began as an interagency collaborative service component that supported the Family-to-Family approach adopted in Riverside County as part of Social Services Re-Design. TDMs with Department of Behavioral Health clinical staff and Department of Public Social Service (DPSS) staff were utilized to problem-solve around the safety and placement of the child when at-home risk resulted in removal from their family.

The Department continues to collaborate with DPSS through Pathways to Wellness, which is the name given to the program to screen and provide mental health services to DPSS dependents to meet the Katie A. vs Bonita class action settlement conditions. RUHS-BH clinical staff supported the Department's Pathways to Wellness implementation through the TDM process and Child and Family Teaming collaborative team meetings. RUHS - BH staff collaborated with DPSS staff at 140 TDM meetings serving 140 youth in FY 23/24
In addition, Department staff participated in several hundred Child and Family Team (CFT) meetings with DPSS staff and families to support creating a family plan through a collaborative process.

Service enhancements for Therapeutic Behavioral Services (TBS) provided additional staff to case-manage youth receiving TBS. TBS services are provided to children with full-scope Medi-Cal and a number of youths without Medi-Cal through Behavioral Coaching Services (BCS). TBS and BCS services are supplied to minors at risk of hospitalization or higher-level placements. TBS expansion staff coordinated referrals and provided case management to 247 youth in FY23/24 with the outcome of increasing access to TBS services. Contract providers include Charlee Family Care, ChildNet Youth and Family Services, Community Access Network, New Haven Youth and Families, and McKinley.

Additionally, California has mandated that youth receive specialty mental health services such as ICC (Intensive Care Coordination) and IHBS (Intensive Home-Based Services) services. All programs that provide children and TAY services must also provide these services to youth who meet the criteria and participate in the CFTs required by the state. This has been an area of focus in this past year and will continue to be in the coming year. Reports regarding the number of ICC and IHBS services provided to each youth are available. These reports are monitored at the program and administrative level for county-operated programs. Contract providers are given reports during technical assistance meetings and the annual contract monitoring process. A report specific to CFTs is being developed.

Clinic expansion programs also included mentors in each county region to provide groups and other services addressing the needs of youth with co-occurring disorders. The Mentorship

Program offers youth receiving services from our county clinics/programs under the age of 18 an opportunity to connect with a mentor for 6 – 8 months. The mentors have varied life experiences and education. Several of the mentors have consumer backgrounds in Children's Mental Health. They have been very successful in working with the youth that are assigned. One of the mentor program objectives is to link youth to an interest in the community. Parents of participating youth have commented that this program helped their child with school and has improved their confidence.

A standalone First Episode Psychosis (FEP) Program has been established to serve the three regions of the County. The program serves youth and young adult who are experiencing their first psychotic episodes. The Department had historically provided some focused efforts to serve this population. However, it became clear that a dedicated program implementing the evidence-based Coordinated Specialty Care Model was needed. The program includes Clinical Therapists, Transition Age Youth Peers, Parent Partners, Behavioral Health Specialists, and a Psychiatrist. The teams continue to receive technical assistance from UC Davis. This has included multiple training sessions for staff at all levels. UC Davis supports the program to meet the fidelity requirements of the CSC model. Twenty-two youths were enrolled in the FEP program, a Full-Service Partnership Program. FSP Outcomes showed a 61% decrease in hospitalizations and a 69.5% decrease in crisis emergency room use. Suspension and expulsions in school decreased, and attendance and grades improved.

Evidence-based practices (EBP) expanded in the children's clinics include Parent-Child Interaction Therapy (PCIT), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and Family Based Treatment (FBT) for Eating Disorders. All were implemented to address the unique needs of the youth population. Staff trained in TF-CBT and FBT continued to expand in FY 23/24. The number of youth served in TF-CBT was 128 youth. The most recent outcomes report showed 52% completed TF-CBT, and over 82 percent of the clients who completed the program completed all of the coping skills phases of the program. 84% of clients completing the program also completed the trauma narrative and processing phase, 28% in-vivo exposure, and more than 75% completed conjoint sessions and enhanced safety. Even amongst clients who did not complete the program, 82% completed psychoeducation, and 66% completed relaxation.

PCIT will continue as a general system development program with an emphasis on expanding capacity by adding four cargo vans that were converted into Mobile Treatment Units to enhance service provision to families with limited resources, such as transportation, and those with geographical barriers. The benefits of utilizing an alternative to the past PEIMS RV units include decreased program expenses, decreased non-clinical duties to operate the RV units, and increased staff focus on consumer services and productivity. Preschool 0-5 has become resourceful in providing services through telehealth, utilizing space at community-based sites, and providing in-home services to continue meeting families' needs. PEIMS staff continue to provide early identification, prevention, intervention, and treatment services to children ages 0-6 and their families in targeted communities across Riverside County.

In addition, a contract expansion with Victor Community Support Services allowed for an additional 0-5 services in the Desert Region of the county, including the expansion of available PCIT services.

Preschool 0-5 Programs include SET-4-School, Prevention and Early Intervention Mobile Services (PEIMS), and the Growing Healthy Minds Initiative. The program uses leveraged funds, including Medi-Cal, MHSA/PEI, and First 5. All program components are implemented through relationships with selected school districts and community-based organization partners. Evidence-based and evidence-informed services are accessible at clinic sites, on mobile units out in the community, and at school sites across Riverside County. Services include a comprehensive continuum of early identification (screening), early intervention, and treatment services designed to promote social competence and decrease the development of disruptive behavior disorders among children 0 through 6 years of age. Services offered within the program are all intended to be time-limited and include the following: Parent-Child Interaction Therapy (PCIT); Parent-Child Interaction Therapy with Toddlers (PCIT-T); Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); Incredible Years (IY); Positive Parenting Program (Triple P); Nurturing Parenting; Education Equip and Support (EES); psychiatric consultation and medication evaluation; classroom support for early care providers and educators; community presentations; and participation in outreach events.

The mission of the Growing Healthy Minds Initiative is to work in partnership with the community to increase opportunities for young children across Riverside County to develop skills and abilities that will prepare them for school and life.

A highlight of the Preschool 0-5 Programs is the celebration of the 20th anniversary of implementing PCIT into the program on May 20, 2023.
Preschool staff continues to train staff in Parent-Child Care (PC-CARE) level II to assist with training another system of care providers with low-intensity treatment options for children not requiring high-intensity treatment, such as PCIT or TF-CBT.

The Growing Healthy Minds Collaborative continues to meet monthly via a virtual platform. The collaborative discussions include program updates and training opportunities and provide a networking space for providers who work with the 0 – 5-year-old population. The Collaborative has proven to be a successful effort that includes an average of 40 multidisciplinary participants per month from locations across Riverside County. The collaborative approach is to assist the system of care providers by increasing their knowledge to assist in diagnosing children under the age of 3 using the DC 0-5 manual. The Collaborative continues to discuss meeting the ongoing needs of the community.

Children's clinic staff were also trained to provide the IY Dinosaur School Program in small groups in each outpatient clinic. This program helps children develop positive coping strategies around behaviors related to anger and other intense feelings. Traditionally, this program was only offered in a school setting, but there was an increased service need for children ages 4-8 who have difficulty managing behavior, attention, and other internalizing problems.

RUHS–BH has continued to experience increased demand for services, and the expansion of contracted providers has occurred to expand these services throughout the County of Riverside. There are 44 contract providers supporting the effort to continue expanding services. In addition, with the implementation of AB1051, RUHS-BH is adding contracts with Short-Term Therapeutic Residential Program (STRTP) providers across the state.

Services to youth involved in the Juvenile Justice system have continued even as the County probation department has changed its approach to incarcerating youth. The Juvenile Halls have dramatically reduced their census over the last few years, choosing instead to serve youth in the community. Behavioral Health programming for justice-involved youth was adopted by increasing Wraparound services and converting the Wraparound Program into an FSP program. In addition, RUHS-BH has expanded aftercare services to youth released from the Youth Detention Facility when sentences were completed. In FY 23/24, Wraparound FSP served 161 youth. Outcomes for Wraparound Youth showed that 55% of the youth closing from the program completed the wraparound program. In addition, Wraparound youth showed a 49% decrease in hospitalizations, a 39% decrease in crisis emergency room use, and a 58% decrease in arrests. For youth showing a high need for the CANS measure in Family Functioning, 34% showed improvement, and for those with a high CANS score for Anger Control, 36% showed improved scores. Substance Use and Conduct also improved, with follow-up CANS scores showing a 34% and 32 % improvement, respectively. The State is developing the High-Fidelity Wraparound requirements, and when they are released, the department will ensure that all of the Wraparound requirements are met. This will include, as a part of the Family First Prevention Services Act (FFPSA), that Wraparound is offered to all youth stepping down from the STRTP level of care.



## *GSD: Clinic Expansion/Enhancements: Adult System of Care*

The Comprehensive Integrated Services for Adults (CISA) Work Plan continues to provide a broad array of integrated services and a recovery-focused supportive system of care for adults with serious behavioral health challenges.

Stakeholders' priority issues identified during the CSS planning process for adults were focused on the unengaged homeless, those with co-occurring disorders, forensic populations, and high users of crisis and hospital services. CISA Work Plan strategies included program expansion, full-service partnership programs, and program enhancements throughout the Adult System of Care. Every Adult Clinic now has an FSP tract which has expanded access to more intensive services when needed. The consumer can easily transition from FSP to non-FSP within their home clinic. The Department has committed to expanding crisis and intensive services, which EBP'S In Outpatient Adult includes expansion of full-service partnership tracts in every clinic countywide. These strategies are intended to be recovery-oriented, incorporating cultural competence and evidence-based practices.

This addition of in-patient hospital linkage to FSP and the out-patient system is having a significant impact on clinic volume and capacity. The Department has continued to employ a

full-time Liaison at the In-Patient Facility (ITF) to support consumers' post-hospital discharge linkage to FSP programs and the Out-Patient Clinics.

Recovery-focused support is a key component in the outpatient clinic system. All System Development programs have enhanced services by integrating Peer Support Specialists and Family Advocates into clinics and programs. Peer Support Specialists have continued to serve as an essential part of the clinic treatment team by providing outreach, peer support, recovery education, and advocacy. Planning for Success (Formally known as Wellness Action Recovery Plan) groups have become well established in our adult clinic system due to the work of Peer Support Specialists. Peer Support Specialists working in the clinics as regular Department employees provide continual support for consumers' recovery. See page 116 for more information about all the activities and services that Consumer Affairs and Peer Support Specialists provide.

Family Advocates have been a critical component of enhanced clinic services. They provide families with resources and information on mental health, diagnosis, the legal system, recovery, and health care system navigation. Any family with questions about the mental health care of their adult loved one can consult with Family Advocates when needed. See page 150 for more information about the Family Advocate Program and all the services that they provide in the Adult System of Care.

Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), EMDR, Seeking Safety, and Co-Occurring Disorder groups are evidence-based practices offered in adult clinics and supported through the Adult Work Plan. Additional treatment for adults with eating disorders is provided using a team approach with behavioral health care staff trained to work and treat Eating Disorders. The Department also committed to implementing an adult trauma-focused practice EMDR and trained 30 practitioners to implement the model throughout the Adult System of Care. The first cohort of staff trained in Eye Movement Desensitization Reprocessing (EMDR) therapy served 47 consumers with this evidence-based practice that is specifically designed for adults who have experienced trauma and or have post-traumatic stress disorder. In the Older Adult System of Care, the Go4Life, a practice developed through the National Institute on Aging, offers seniors whole health benefits related to integrated care.

All adult services staff are mandated to be trained in Trauma Informed Services (TIS) to ensure that all staff are providing services in a trauma-informed approach. This implementation in TIS has continued with various practices throughout the department to reinforce this trauma-informed approach. For example, many staff meetings begin with a TIS moment which may be trauma care from a consumer perspective or trauma care to supporting staff as they do their work.

**Evidence-Based Practices in Outpatient Adult Mental Health Services**

Our Outpatient Adult Mental Health Services utilize evidence-based practices (EBPs) to provide practical, research-backed treatment for individuals experiencing mental health challenges. These practices are grounded in scientific research and clinical expertise, ensuring

high-quality, patient-centered care that leads to meaningful recovery and improved well-being.

**Key evidence-based approaches include:**

- **Cognitive Behavioral Therapy (CBT):** Helps individuals identify and change negative thought patterns and behaviors.
- **Dialectical Behavior Therapy (DBT):** Supports emotional regulation and distress tolerance, particularly for individuals with mood disorders.
- **Motivational Interviewing (MI**): Encourages individuals to build motivation for positive change.
- **Medication Management:** Provides psychiatric evaluations and medication support tailored to individual needs.
- **Trauma-Informed Care**: Recognizes the impact of trauma on mental health and integrates strategies to foster resilience.
- **Peer Support & Psychoeducation:** Engages individuals in learning coping strategies and building social support networks.

Our commitment to EBPs ensures that clients receive treatments that are proven to be effective. This leads to better symptom management, increased independence, and a higher quality of life overall.



### Pathways to Success

Pathways to Success is a Riverside University Health System—Behavioral Health vocational program that provides services in partnership with the California Department of Rehabilitation. It provides vocational services to individuals 18 years of age and older who are receiving services from any RUHS—BH Western or Mid-County Region program or any RUHS—BH contracted Behavioral Health service provider within the Western and Mid-County Region. The program collaborates with the California Department of Rehabilitation (DOR).

The program will participate in a site review with DOR in June 2024 to address the objectives and goals to sustain the program and enhance and maximize service delivery for Riverside County consumers. The program is expanding its collaboration to the transitional-aged youth FSP programs. The program staff is conducting orientation in the western, mid-county, and desert regions.

### Telepsychiatry Program

The Telepsychiatry Program provides accessible, high-quality mental health care through secure, virtual platforms. It allows individuals to connect with licensed psychiatrists and mental health professionals from the comfort of their own homes. Designed to reduce barriers to care, our program serves individuals in remote areas, those with limited mobility, and anyone seeking convenient, confidential psychiatric support.

Through video consultations, our psychiatrists offer comprehensive mental health assessments, medication management, therapy referrals, and crisis intervention when

needed. The program is committed to delivering timely, patient-centered care while ensuring privacy and adherence to all healthcare regulations.

By integrating telehealth technology with mental health services, our Telepsychiatry Program enhances access to care, promotes continuity of treatment, and supports individuals in managing their mental well-being effectively.

Telepsychiatry will move to in-person care. Here are some estimates for service data: These are estimates. Roughly 75% in-person/office, 14% phone, 7% field-based, 1-2% Telepsychiatry. We are going to open the Franklin Adult Residential Facility, which has 84 beds, next month. Roy's Jr.

## *Adult GSD: RUHS-BH Long-Term Care (LTC) Expansion*

The RUHS-BH Long Term Care (LTC) program operates under the auspices of the Riverside University Health System – Behavioral Health, Office of the Public Guardian. It serves conserved individuals with severe and persistent mental illness who often require hospitalization or out-of-home placement. LTC, in collaboration with the Public Guardian's Office, strives to ensure that each Conservatee is served in the least restrictive setting/environment in which the consumer's safety, health, and wellness are the priorities.

For Conservatees in need of residential treatment programs, LTC performs and/or participates in biopsychosocial assessments, treatment planning, recommendations, and linkage services. LTC creates daily partnerships with the Conservatees and their respective Public Guardian Conservators, consumers' family members, psychiatrists and medical experts, hospital staff, placement staff, and other collateral resources. LTC endorses treatment and service plans that are clinically effective and cost-effective for the consumer. Overall, the LTC Program's mission is to promote hope, wellness, and recovery for conserved individuals with serious mental illness and other psychiatric disabilities.

The LTC clinicians and case managers provide case management, supportive counseling, and discharge planning services for Conservatees placed at psychiatric hospitals, IMDs, and residential care facilities (also known as board and care facilities). To streamline the continuum of care for the Conservatees, the LTC staff collaborate closely with the Public Guardian – Lanterman-Petris-Short (LPS) Conservators. LPS conservatorships are used to care for adults with a grave disability who need special care and protection. These conservatorships benefit individuals who are often in need of restrictive living arrangements (such as locked mental health facilities) and require intensive mental health treatment and supportive services to complete activities of daily living.

The LTC staff coordinate their case management services with the consumer's LPS Conservator, and together these staff members assist the Conservatees with navigating through the various levels of care, from inpatient acute hospitalization to long-term care facilities and eventually to the community-based residential placements or homes. While the PG LPS Conservators are tasked with advocating for the least restrictive placement for their

Conservatees, establishing and maintaining benefits, managing their finances, marshaling and safeguarding their property and assets, the LTC team is tasked with coordinating placement plans and transfers and monitoring the consumers at the facilities to ensure appropriate client-centered care.

While the LTC program primarily supports the Public Guardian LPS conservatorship program, it also provides placement assistance for the Public Guardian Probate program. Currently, there are over 1,300 conserved individuals in the Public Guardian LPS and Probate programs.

The LTC program maintains placement contracts with facilities that offer a continuum of long-term care, including Inpatient Treatment Facilities, State Hospitals, Institutions for Mental Disease, Mental Health Rehabilitation Centers, specialized Skilled Nursing Facilities, Assisted Living Facilities, Augmented Board and Care facilities, and Adult Residential Treatment facilities. Additionally, in response to the need for additional safe, secure, and appropriate housing for the growing Conservatee population, RUHS-BH has designed, constructed, and implemented placement facilities operated by contract providers primarily for the Public Guardian's Conservatees. These dedicated placement facilities include:

- Riverside County Telecare Mental Health Rehabilitation Center (MHRC), in Riverside, CA – operated by Telecare Corporation – 79 beds
- Restorative Transformation Center, in Riverside, CA – operated by Telecare Corporation – 30 beds with 10 beds to be available to Public Guardian Conservatees
- Roy's Desert Springs Adult Residential Facility, in Indio, CA - operated by MFI Recovery – 92 beds
- Desert Sage Adult Residential Facility, in Indio, CA - operated by MFI Recovery – 49 beds
- Franklin Residential Care and Behavioral Health Clinic, in Riverside, CA – RUHS-BH's newest augmented board and care facility, which is expected to open in March 2025 and will be operated by MFI Recovery – 84 beds

**CONSUMER SATISFACTION SURVEY**

According to LTC's 2022-23 plan to design and implement a brief client satisfaction survey geared towards the Conservatee population, a Public Guardian Consumer Satisfaction Survey was created and implemented by the RUHS-BH Research and Technology Department in July 2023. A Total of 157 Conservatees, out of 978 Probate and LPS Conservatees, participated in the survey. Participants resided at various levels of care, including mental health rehabilitation centers (MHRC), an Institute for Mental Disease (IMD), an augmented board and care facility, and board and care facilities. The survey contained seven questions, with six of the questions measuring responses on a Likert scale and the seventh employing an open-ended narrative section. While only 16.1% of all Public Guardian Conservatees completed the survey, factors contributing to the low participation rate in the survey include the Conservatees' severe and persistent mental health impairments, cognitive deficits, developmental disabilities, non-verbal or non-responsive status, and survey administration issues.

| SURVEY QUESTIONS | AGREED STRONGLY AGREED | NO RESPONSE RECEIVED |
|---|---|---|
| 1. I am safe and welcome in my living environment. | 72.0% | 11.5% |
| 2. I feel like my needs are being met. | 77.1% | 5.7% |
| 3. I feel like my opinions are taken into consideration. | 64.3% | 13.4% |
| 4. I am visited enough by my Deputy Public Guardian. | 51.6% | 8.3% |
| 5. I can easily contact my Deputy Public Guardian. | 67.5% | 7.6% |
| 6. When staff are not able to help me, they help me understand why. | 71.3% | 13.4% |
| 7. Comments:<br>➢ Four Conservatees desired more interactions with their Conservator.<br>➢ Three requested placements at a lower level of care, such as a board and care or room and board.<br>➢ Three requested resources, including clothing, food, and medicine.<br>➢ Three were non-verbal but indicated that the Deputy Public Guardian pays their facility payments and monthly personal needs allowance.<br>➢ Twenty-seven Conservatees requested more facility outings, such as going to the DMV or spending time with their family.<br>➢ Finally, twelve Conservatees denied having issues they wished to comment on. | | |

**COMMUNITY REINTEGRATION**

The LTC program seeks to generate FSP and CARE Act referrals for all conserved consumers residing in adult residential facilities in Riverside County to ensure that each Conservatee receives wraparound services through regional FSP programs and other outpatient programs. The ultimate goal is to optimize each individual's adaptive functioning and facilitate his or her ability to gain self-sufficiency and live independently with assistance from community-based supports and services without the need for being managed by a court-ordered conservator.

In Fiscal Year 2022-2023, LTC implemented a Full-Service Partnership (FSP) track for LPS Conservatees who have been hospitalized in an acute care setting or have been placed in transitional residential care facilities, such as the Riverside County Telecare Mental Health Rehabilitation Center in Riverside. Referrals for FSP services aim to facilitate the Conservatees' access to wraparound services and enhance their overall functioning and capacity for self-sufficiency while living at community-based facilities. In Fiscal Year 2023-2024, 111 Conservatees were linked to FSP wraparound services. While the residential treatment facilities continued to provide wraparound services for each consumer, the LTC program concurrently offered case management, placement coordination, and linkage services for the Conservatees, to transfer the Conservatees into less restrictive, lower levels of care.

In September 2024, the Long-Term Care team-initiated referrals to the RUHS-BH Community Assistance, Recovery, and Empowerment Act, also known as the CARE Act. The CARE Act program is a collaborative civil court process that provides participants with clinically appropriate, community-based services, including medication management, behavioral health treatment and services, assessment and care planning, case management services, psychoeducation, and linkages to other social services, such as supportive housing resources for persons with schizophrenia and other psychotic disorders. The CARE Act presents an ideal, voluntary opportunity for Public Guardian Conservatees to step down to a lower level of care and still receive support from a professional social services network for up to two years. As of February 2025, seventy-five Conservatees have been identified as appropriate candidates for the CARE Act program. All Conservatees being referred are residing in the board and care or augmented board and care placement level and are demonstrating readiness to live independently and re-integrate into the community. While many of these Conservatees initially expressed anxiety and apprehension about leaving the safety net provided by conservatorship, six Conservatees are actively engaging with the CARE Act outreach team to pursue the possibility of conservatorship termination and community reintegration with support from the CARE Act program.



## Adult GSD: Representative Payee Program

The goal of the Representative Payee (RP) program is to provide money management services on a voluntary basis to clients of Riverside University Health System – Behavioral Health (RUHS-BH) who are unable to manage their funds effectively as a result of their mental illness. The Representative Payee services are intended to be time-limited and are provided while the client and their treatment team improve the client's money management skills to the point where Representative Payee services are no longer necessary, or another responsible third party can take over the responsibilities.

All clients in the RP program will have an open episode at a County clinic and an assigned case manager. The Public Guardia's RP program staff provides the accounting functions, but does not provide mental health treatment or case management services to clients

### *Older Adult System Of Care*

Clinic Expansion/Enhancements: Older Adult Integrated System of Care
Riverside University Health System-Behavioral Health is dedicated to supporting the programs of the Older Adult Integrated System of Care (OAISOC), which serves individuals with severe behavioral health challenges. The Department is committed to sustaining all other programs listed in the Older Adult Integrated work plan, including Peer and Family Support, Family Advocates, and Clinic Enhancements.

The OAISOC Work Plan includes strategies to enhance services by providing staffing to serve older adult consumers and their families at regionally based older adult clinics (Wellness and Recovery Centers for Mature Adults) and through designated staff expansion located at adult clinics. Older Adult Clinics are in Desert Hot Springs, San Jacinto, Riverside, Lake Elsinore, and

Temecula, and expansion staff are located at adult clinics in Perris, Banning, and Indio. The Wellness and Recovery Centers have continued to innovate by developing enhanced psychological/psychotherapeutic services as part of assessment and evaluation. Older Adult clinic programs and expansion staff combined served 3,369 older adult consumers through a two-track system: Wellness and Recovery Programs (2,810) and (559) Full-Service Partnership (FSP) Programs at each clinic location.

The clinic Wellness and Recovery Programs track is designed to empower mature adults who are experiencing severe and persistent mental health challenges to access treatment and services to maintain the daily rhythm of their lives. The Wellness and Recovery Centers for Mature Adults provide a full spectrum of behavioral health services, including psychiatric services, medication management, physical health screenings, case management, individual therapy, and group therapies. The clinics currently offer over 27 psycho-educational multi-discipline groups led by therapists, nurses, behavioral health specialists, peer support specialists and family advocates. The groups currently offered include SAMSHA Wellness Curriculum, integrated Fit for Life evidenced-practice holistic health groups, traditional group therapy, healing art, Core, Facing Up, Cognitive Behavioral Therapy for Depression, Anger Management, Cognitive Behavioral Therapy for Psychotic Symptoms, Seeking Safety, Dialectical Behavioral Therapy, Bridges, Grief and Loss, Brain Disorders and Mental Health, Creative Arts, Art Therapy, Computers, Chronic Medical Conditions, Coping skills, and Co-Occurring Disorders.

In addition, we have developed Spanish psychoeducational groups, SAMSHA Wellness Curriculum, for monolingual older adults. Moreover, at three of our Wellness and Recovery Centers (Rustin, Lake Elsinore, and Temecula), we have implemented Drop-in Mindfulness Centers, utilizing the family room model for the older adults we serve. Peer Support Specialists work hand in hand with clinicians and other behavioral health staff to provide the full array of groups. A new resource center has enhanced the core services in the Temecula Wellness and Recovery Center by adding a member computer library where clinic staff can assist consumers in accessing technology-based resources while improving their computer knowledge and skills. The mind-brain technological development for the mature adult group is the going forward addition to this center. The center increases access to other agencies that specialize in Older Adult related services such as RUHS Medical Center, Community Health Centers, The Office on Aging, and Adult Protective Services (APS).

Further, it improves access and maintenance of older adult benefits, entitlements, and resources such as Social Security, Medicare, and Medi-Cal, as well as assistance agencies such as the Health Insurance Counseling & Advocacy Program (HICAP), California Healthcare Advocates, and other essential community partners.

All mature adult services staff have been trained in Trauma Informed Services (TIS) to ensure that all staff are providing services using a trauma-informed approach. This approach has been implemented throughout Riverside University Health System-Behavioral Health.

The proportion of older adults served across the county is close to the county population, with 26% Hispanic/Latino served and a county population of Hispanic/Latino older adults at 32%. The Caucasian group served 44%, and the Black/African American group served 11%. The Asian/Pacific Islander group served 3%, which is less than the county population of 8% Asian/Pacific Islander.

Finally, RUHS-BH is committed to sustainable and ongoing efforts to address the unmet needs and social determinants of older adults in Riverside County. The older adult population remains one of the fastest-growing and most vulnerable populations in Riverside County; therefore, we will continue to place much emphasis on expanding services and improving access throughout all regions of the County.

## *GSD: Crisis System of Care*

### *Behavioral health- mobile crisis response teams (MCRT)*

Mobile Crisis Teams have been in operation since 2014 and have continued to expand and evolve. The original stakeholders include Law Enforcement, Hospital EDs, Community Health Care Clinics, Schools, Outpatient programs, Adult Protective Services, Child Protective Services, and many more. Additionally, requests directly from the community are also responded to. As of December 31, 2023, mobile crisis response teams are now available throughout the county 24 hours a day, 7 days a week, and 365 days a year.

Mobile Crisis Response teams meet the needs of the community by providing an immediate supportive crisis response focused on successfully diverting consumers in crisis away from emergency departments, law enforcement, incarceration, and psychiatric hospitalizations whenever possible. Mobile crisis response teams are focused on de-escalating, supporting, collaborating with support persons, and developing strong safety plans for all individuals and families that are served. Mobile crisis response teams are typically teams that include a clinical therapist and a peer support specialist. In addition to the crisis response, the team also conducts follow-up support within 72 hours to ensure that the consumer is using the safety plan and to assist with reducing any barriers to using and linking to referrals that have been provided. These teams have been extremely successful in reducing the number of admissions at our County Emergency Treatment Services (ETS).

In FY 23/24, MCRT teams responded to over 2,200 requests for mobile crisis response. Please see the data in the figure below.

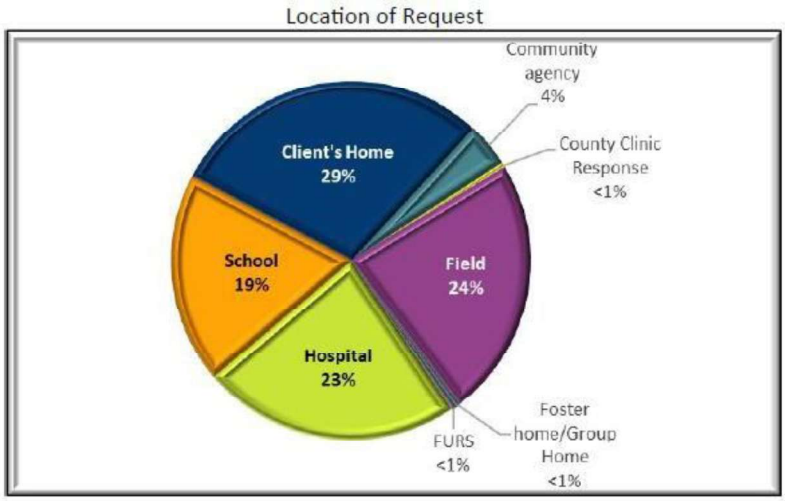
design was to dispatch crisis teams at the request of Law Enforcement and Hospital Emergency Department stakeholders. Over the past few years, the program has evolved to

include dispatching teams to requests from multiple

| MCRT Crisis Requests 2,282 | |
|---|---|
| West | 843 |
| Mid-County | 863 |
| Desert | 576 |

| Avg. Num. of Requests per Month |
|---|
| 190 |

Twenty-nine percent of the MCRT requests were to members' homes, followed by 23% at hospitals.




Response times were an hour or less for 58% of responses. A total of 67% of requests for mobile crisis response were diverted from inpatient admission or crisis emergency room use. After MCRT contact, 92% of those served did not show any inpatient psychiatric admissions within 60 days of MCRT team contact. Thirty-four percent (38%) of the consumers MCRT teams served were linked with outpatient care, and 85% of those linked received three or more services.

**Goals of the 3-Year Plan:**

1. 45% of consumers served will link with outpatient services after contact with the crisis teams.

2. MCRT will increase stakeholders by continuing to promote and outreach to law enforcement, schools, foster homes, group homes, and community colleges.

MCRT will Increase linkage to Mental Health Urgent Cares for youth (13 to 17 years) experiencing a behavioral health crisis.

**MCMT=Mobile Crisis Management Teams**

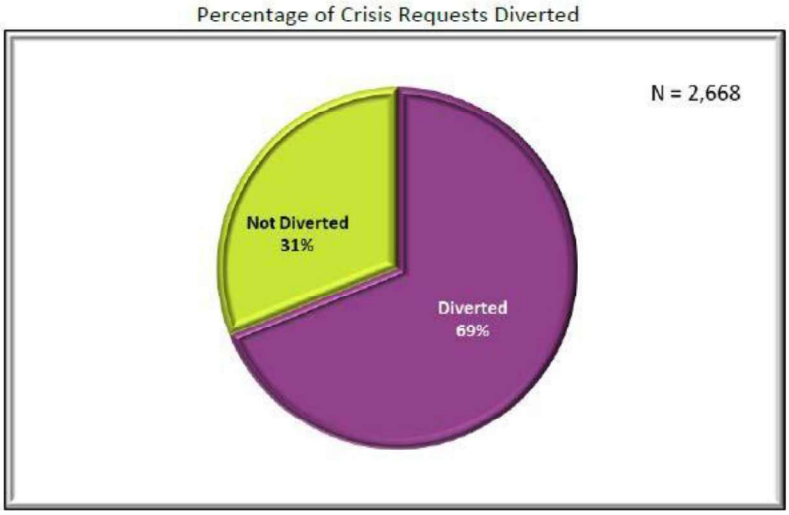
The Crisis Support System of Care expanded in the fiscal year 2021/2022 by planning the addition of 15 Mobile Crisis Management Teams to the four existing teams, resulting in 19 teams. These teams comprise four multidisciplinary staff members: clinical therapists, peer support specialists, behavioral specialists III (substance use counselors), and behavioral health specialists II. These staff have specialty training in crisis intervention, risk assessment, peer support, and intensive case management services to include homeless outreach and housing as well as substance abuse assessment, counseling, and linkage to residential treatment. The MCMT teams respond to crisis calls in the community and provide short-term treatment while assisting consumers in establishing connections to longer-term treatment services.

MCMT staff also engage in outreach activities and events to engage homeless and unengaged individuals in services. In Fiscal Year 23/24, Mobile Crisis Management Teams provided services to all ages and populations throughout Riverside County. An emphasis is placed on collaborating and coordinating with local cities to partner in efforts to engage and prevent crises with vulnerable populations such as homeless individuals and families. The locations for the teams include Perris, Jurupa Valley (2 teams), Desert Hot Springs, Lake Elsinore, Banning (2 teams), Riverside (2 teams), Hemet (2 Teams), Temecula, Menifee, Indio (2 teams), Blythe, Corona, Moreno Valley (2 teams). These teams support the communities and surrounding areas. FY 23/24 was focused on strengthening community partnerships.

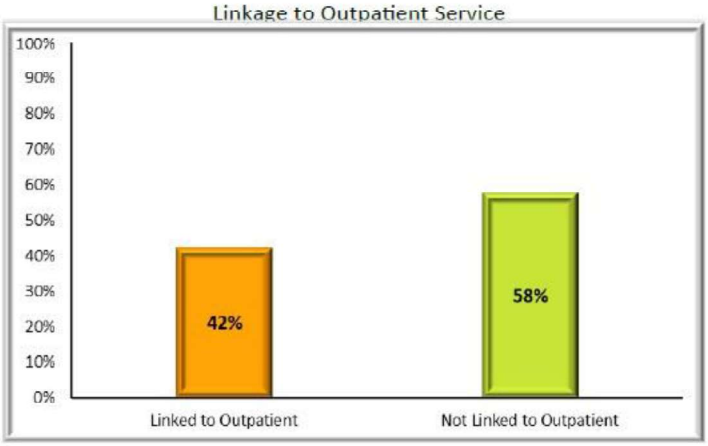
The goals of MCMTs are to be responsive and person-centered and use recovery tools to prevent crisis, support individuals in crisis, and divert unnecessary psychiatric hospitalization whenever possible. Additional goals include engaging and linking individuals and families into behavioral health services and substance use services, as well as reducing law enforcement and emergency department demands from consumers needing behavioral health and substance use services.

During FY 2023/2024, Mobile Crisis Management Teams responded to 3,400 requests for crisis intervention and outreach. They were able to safety plan and divert 69% of crisis requests from an inpatient admission and link 42% of individuals served to outpatient services. Please see the figure below for data.

| MCMT Requests 3,411 | |
|---|---|
| Crisis | 3,013 |
| Homeless Outreach | 296 |
| MCMT Non-Crisis Outreach | 97 |
| Welfare Check | 5 |




MCMTs were able to divert 69% of crisis requests from an inpatient admission.




Forty-two percent (42%) of individuals served by MCMTs had an outpatient service after contact with teams. Some of these individuals (n = 421) were participating in outpatient services prior to their contact with teams.

**3-Year Plan Goal**

e. 55% of consumers served will be successfully linked with outpatient services after contact with the teams.

## *Community Behavioral Assessment Team (CBAT)*

The Community Behavioral Assessment Team (CBAT) is a co-responder team comprised of a clinical therapist and a law enforcement officer (Sheriff or PD). Recognizing the role of law enforcement and the mental health needs of community members, this particular crisis response model was first implemented over 6 years ago with the Riverside Police Department, followed by the Hemet Police Department in 2017. CBAT is a special unit that responds to psychiatric inpatient hospitalizations whenever possible, decreases incarceration, decreases ED admissions, reduces repeated patrol calls, makes appropriate linkages to care and resources, and strengthens partnerships between the community, law enforcement, and behavioral health.

CBAT locations expanded from two teams, Riverside Police Department and Hemet Police Department to three additional sites in FY18/19: Indio Police Department, Southwest Sheriff,

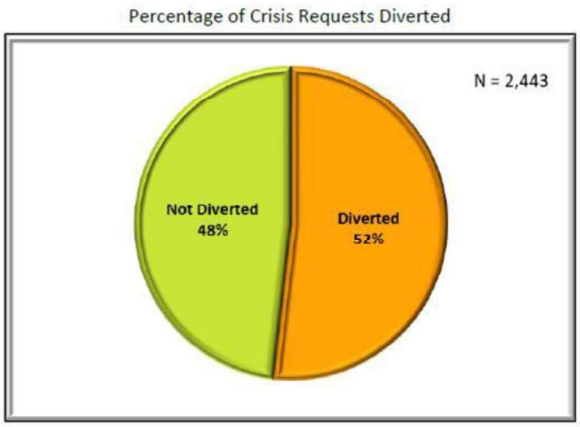
and Moreno Valley Sheriff. FY 19/20, the Riverside Police Department acquired a second CBAT unit, and the Murrieta Police Department with their first.

FY20/21 brought continued CBAT program growth with the approval of 10 additional CBAT units countywide. RUHS BH expanded its collaboration and partnership with the Sheriff's Office (to include) – Perris, Jurupa, Hemet, Palm Desert, Cabazon, Lake Elsinore, and Thermal stations. In addition, 4 Police Departments also adopted the CBAT program – Corona, Menifee, Cathedral City, Murrieta, Banning, and Beaumont Police Departments. (Cabazon, Banning, and Beaumont share a clinician).

The expansion of the CBAT program speaks to its success. The co-responder model has demonstrated the value in emergency response regarding timeliness response to a crisis, the value of two professions working together to address the clinical and legal ramifications, diversion, stigma reduction, and linkage to continued care when possible.

In fiscal year 2023/2024, CBAT responded to over 8200 requests for service. See the data below.

911 behavioral health-related crisis calls, mental health emergencies/5150, substance abuse, and homeless-related crisis. CBAT serves all populations. CBAT provides rapid response field-based risk assessment, crisis intervention, and de-escalation, linkage, and referrals. One of the goals of CBAT is to offer field officers a resource for calls that require more time and specialized attention. In addition, the goal of CBAT is to divert and decrease




CBATs were able to divert 52% of Crisis requests.

| CBAT Requests 8,274 | |
|---|---|
| Crisis | 3,400 |
| Homeless Outreach | 1,710 |
| Welfare Check | 3,164 |

Avg. Number of Calls per Month
690

## *MPS=Mobile Psychiatric Services*

The Mobile Psychiatric Services (MPS) program provides integrated behavioral health (BH) services for consumers with severe and persistent mental illness who are high utilizers of crisis services and frequent hospitalizations with little to no connection to outpatient services. The MPS program strives to provide an accessible, culturally responsive, integrated, and best practice-based system of behavioral health services to support consumers in their recovery.

**OVERVIEW**

Mobile Psychiatric Services (MPS) provides field-based services to engage and treat high utilizers of crisis services, including hospital-based services, who frequently have not had success in engaging in traditional outpatient services. MPS outreaches and engages consumers who are identified as having frequent crisis services. The goal is to actively engage consumers where they are and eventually initiate intensive case management services. Once consumers are engaged in services and no longer utilizing frequent crisis services, they will be connected to appropriate and existing outpatient services for continuity of care.

This MPS program provides services including mobile response, psychiatric assessment, medication consultation, assessment, and medication management, case management, therapy, and behavioral management services, substance abuse screening, and referral to

outpatient services for any consumer who is a high user of crisis services but not currently engaged in more traditional outpatient BH services.

The goal is to provide a collaborative, cooperative, consumer-driven process for providing quality behavioral health support services through the MPS team's effective and efficient use of resources. The goal is to empower consumers through case management and street-based medication services and draw on their strengths and capabilities. The goal is to promote an improved quality of life by facilitating access to necessary supports to eventually and effectively engage in the variety of outpatient services that are offered throughout the county, thus reducing the risk of hospitalization.

**TARGET POPULATION**

High-utilizer consumers could be short-term or long-term. They can be seen in a motel, home, room, and board and/or board and care facilities, sober living facilities, or homeless encampments.

In FY 23/24, MPS provided 2,530 services (an increase of 113% from last FY) to 103 consumers. Thirty-seven percent of those services were medication services we provided mainly in the field.

**3-Year Plan Goal Progress**

1. Increase the total number of consumers served to 150.

**Annual Update: Progress Report on 3-Year Plan**

Here is the progress update) on MPS for FY 23/24:
Patients engaged by MPS saw a 44% drop in admissions to mental health crisis service units, a 41% drop in admissions to mental health urgent care, and a 16% drop in inpatient hospitalizations. The county saves an average of $20,000 for every inpatient admission avoided from its general fund.

One of the program's greatest successes is its ability to help its patients begin using clinics and obtain rehabilitative care. One internal review of utilization between July 2018 and March 2020 found that 73% of patients were linked to and received services in county outpatient and/or substance use programs.

A big part of the success of MPS is its staff teamwork, and the patients sense that, too, Weigold said. "If it needs to be done, they're happy to do it…. Nobody gets hung up on, 'Well, that's not my job, that's not my classification.'"

MPS serves most patients for an average of six months to two years. When they demonstrate their ability to meet their behavioral health needs, it prompts one of MPS staff's most challenging conversations: telling a patient they've "graduated" from their service.

> "They've never had somebody who would follow them and assist them with every little thing, whether it's trouble with a roommate at the

rehab to being out of food and the food bank is closed," Weigold said. "There's generally some weeping and wailing over having to leave us."

One 40-year-old homeless man turned his whole life around after MPS started him on medication for his mood disorder and also connected him with simultaneous substance use disorder care. The man got a job, was accepted into his family, and returned to living with them. He then launched a small nonprofit, visiting churches in Southern California to tell his inspiring story and encourage others who are struggling similarly.

Now, the patient visits MPS staff about once a month to say, "Thank you."

Consumers Served: The MPS outreach team served 102 consumers from July 1st, 2023, to June 30th, 2024. The team served primarily the Western region of Riverside. Considerable outreach efforts may be needed to locate and engage the consumers in direct services. Not all consumers are found or agree to accept services.

Direct Services Data: 102 consumers received direct services from MPS. Table 1 summarizes the MPS direct services provided. The mobile psychiatry team provided 2,530 services totaling 3,539 hours to 102 consumers between July 1, 2023, and June 30, 2024. Many of these services were mental health rehabilitation (38%), medication services (30%), consumer support services (14.5%), and case management (6.2%).

MPS was recognized in Psychiatry Online Journal for its unique program and services:
https://psychiatryonline.org/doi/10.1176/appi.pn.2025.02.2.10
Here is the exert of the first section of the journal article content:

**Mobile Psychiatry Unit Brings 'Concierge-Level' Service to Highest-Need Patients in Riverside**
A mobile psychiatry clinic is bringing medications, mental health rehabilitation, and social services directly to a select list of at-risk residents in one California county, reducing inpatient and crisis service utilization and helping them turn their lives around.

When Scott Weigold, M.D., was called into the office of the medical director at Riverside University Health Services-Behavioral Health (RUHS-BH) toward the end of the day eight years ago, he wondered what it was about.

As it turned out, Weigold—who was a staff psychiatrist at RUHS-BH—was briefed on the results of a new utilization analysis: A relatively small number of Riverside, California, residents—about 350—were responsible for $8 million in mental health crisis and emergency services in just one year. Weigold was tasked with solving this unsustainable situation.
"We noticed right away that these people were not utilizing our regular outpatient clinics," he said. "So, we started discussing how we could arrange care for these people in a humane and clinically responsible way that would also reduce their number of crisis visits, which are hugely expensive, intrusive, and don't provide any ongoing, organized, long-term treatment."

They devised the idea for the RUHS-BH Mobile Psychiatric Service (MPS). “They’ve already shown us that they cannot effectively utilize a brick-and-mortar clinic,” Weigold said. “So, we need to take clinic services to them until they are restabilized and able to use a more traditional clinic.”

MPS has four vehicles roving Riverside County, providing on-the-spot mental health rehabilitation and medication services, substance use care, consumer support, and case management in addition to Weigold, psychiatry residents, a dedicated substance use counselor, a therapist, case managers, peer support specialists, and a community service aide staff the mobile team. At most, two or three of them ride around together at one time to not overwhelm patients.

Unlike some mobile services, MPS is not tasked with responding to 911 calls or adding new clients upon request from courts or caregivers. Instead, this specialized team focuses solely on meeting the needs of county-identified “high utilizers” of mental health emergency services.

A recent internal review found that about 58% of MPS patients had a primary diagnosis of schizophrenia or psychosis, while 14% had primary substance use disorder. Weigold estimates that about 80% are homeless.

Staff locates patients using old addresses, hangouts, phone numbers, family members, job sites, or prior clinicians. They may also wait until patients appear at various emergency care clinics.

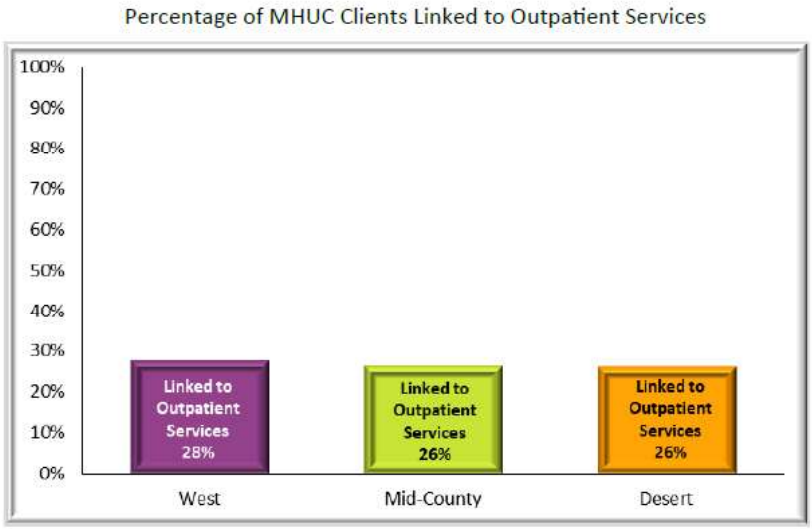


**MHUC=Mental Health Urgent Cares**

Mental Health Urgent Care (MHUC) is a 24/7 voluntary crisis stabilization unit. The consumers can participate in the program for up to 23 hours and 59 minutes. The average length of stay is 8-14 hours. The consumer and their family receive peer navigation, peer support, counseling, nursing, medications, and other behavioral health services. The goal is to stabilize the immediate crisis and return the consumer to their home or to a Crisis Residential Treatment Program. The secondary goal is to reduce law enforcement involvement, incarceration, or psychiatric hospitalization.

MHUCs serve individuals identified, engaged, and referred by Mobile Crisis Teams, Law Enforcement, Crisis Hotlines, and community-based agencies. MHUCs also serve as crisis support for walk-in self/family referrals. While the facilities primarily serve consumers aged 18 and older, the capacity to serve adolescents (ages 13-17) was added in the Desert and Mid-County MHUCs. This results in a more recovery-oriented service delivery and a cost savings from unnecessary higher levels of care. During the 2023/2024 fiscal year, MHUCs had 12,706 admissions and served 6,630 unduplicated clients.

The MHUCs assist consumers at discharge with linkage to outpatient services. The percentage of consumers linked to outpatient services after an MHUC admission varied by MHUC region. Please see the figure below for data.




**Continue 3-year Plan Goals:**

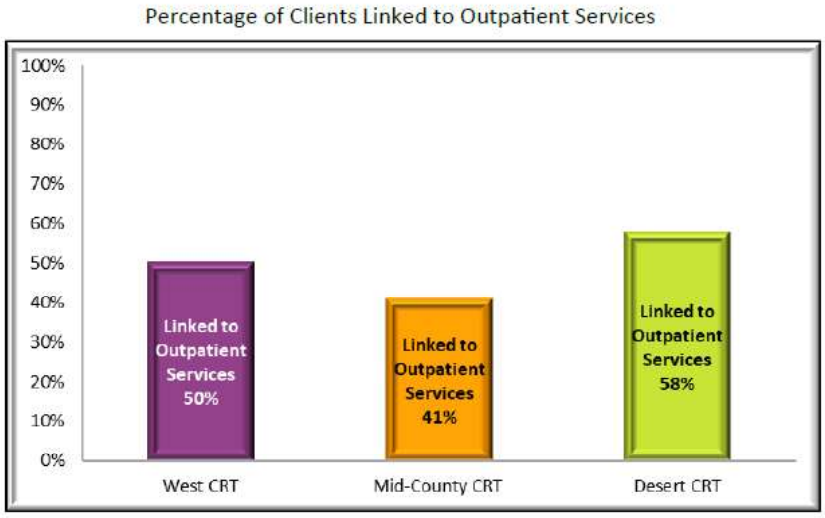
1. 3 year: at least 70% of consumers successfully discharge with referral to mental health or substance use services

2. 3 year: 45% of consumers successfully attended at least one mental health or substance use service post discharge.

**CRT=Crisis Residential Treatment**

Located in each of the three county regions, Adult CRT facilities are licensed by Community Care Licensing as Social Rehabilitation Programs (SRP). Consumers are offered a 21-day stay, with extensions up to 30 days. The CRT can accommodate 15 to 16 adults aged 18 and older who require crisis stabilization. Nearly 100% of the consumers are Medi-Cal recipients. Emergency Departments, Mental Health Urgent Care centers, Crisis Stabilization Units, Emergency Treatment Services, Psychiatric Hospitals, and the Riverside University Health System – Behavioral Health outpatient system of care refer consumers to this program. It is designed to prevent psychiatric hospitalization, provide a step down from psychiatric hospitalization, and assist consumers in stabilizing their symptoms before transitioning to other forms of treatment, such as residential substance use treatment and traditional outpatient services. Designed to create a home-like service environment, the CRT features a living room with more negligible activity and conversation areas, private interview rooms, a family/group room, eight bedrooms, and cooking and laundry facilities. The goal is to assist consumers with the circumstances leading to their crisis, help them return to a pre-crisis state of wellness, and connect them to peer and other behavioral health services.

During the 2023/2024 Fiscal Year, the Crisis Residential Treatment (CRT) facilities had 928 admissions and served 815 consumers. The CRTs support consumers at discharge by linking them to outpatient services. The percentage of consumers related to outpatient services after admission to a CRT remains consistent across regions and facilities. Please see the figure below for data.




**Re-admission rates to the CRTs within 15 days or less were relatively low. See the data below.**

| Recidivism Rates for CRTs | | | |
|---|---|---|---|
| Days to Readmission | West | Mid-County | Desert |
| 0 to 15 Days | 7% | 4% | 8% |
| 16 to 30 Days | 6% | 3% | 4% |
| 0 to 30 Days | 12% | 7% | 12% |

**3-Year Plan Goal**

1. 75% of consumers successfully discharge with a referral to mental health or substance use services

2. 60% of consumers will be linked to outpatient services.

Riverside University HEALTH SYSTEM Behavioral Health

# Crisis Support System of Care Report

## Fiscal Year 2023/2024

## *Crisis Support System of Care (CSSOC)*

**Brief Program Overview**

RUHS-BH has established a Crisis Support System of Care (CSSOC). Mobile Crisis Response Teams (MCRT), Mobile Crisis Management Teams (MCMT), Community Behavioral Health Assessment Teams (CBAT), Community Assessment Transport Team (CATT), and Behavioral Health Justice Intervention Services (BHJIS) teams provide mobile crisis intervention services at various locations in the community. Mental Health Urgent Cares (MHUC) and Crisis Residential Treatment (CRT) facilities provide crisis support and stabilization. Together, these programs provide crisis support, diversion from emergency psychiatric services, and connection to outpatient services. Beginning in January 2024, MCRT and MCMT teams provide crisis intervention services 24 hours a day, 7 days a week to various locations within the county with follow-up completed within 72 hours of a crisis contact.

**Mobile Crisis Response Teams (MCRT)**

Designed to decrease law enforcement involvement and inpatient admissions, MCRTs provide mobile based crisis support and connection to outpatient/substance services. Teams consists of a Clinical Therapist II or a Behavioral Health Specialist and a Mental Health Peer Support Specialist. Originally designed to provide crisis services to adults, teams were added specifically to provide services to youth age 21 and younger.

**Mobile Crisis Management Teams (MCMT)**

MCMTs assess and intervene with individuals experiencing a mental health crisis. Teams consists of four staff members: Clinical Therapist, Behavioral Health Specialist II, Behavioral Health Specialist III, and Peer Support Specialist.

**Community Behavioral Health Assessment Teams (CBAT)**

Comprised of a specially trained police officer and a RUHS-BH Clinical Therapist II, CBATs respond to requests for law enforcement services involving individuals who are experiencing a mental health crisis and divert these individuals to the appropriate community and behavioral health services.

**Community Assessment and Transport Team (CATT)**

The CATT team pairs a RUHS-BH Clinical Therapist with an EMT American Medical Response (AMR) to respond to individuals experiencing a mental health crisis in the City of Hemet. The team provides mental health assessment, resource referrals, and transportation when necessary to mental health and substance use facilities as well as to shelters for individuals who are dealing with mental health and/or substance issues.

**Behavioral Health Justice Intervention Services (BHJIS)**

BHJIS teams provide responsive crisis intervention support, reduce hospitalizations and arrests, and connect students with on-going supports and services at colleges in the community. Two RUHS-BH Clinicians provide crisis services at four college campuses: College of the Desert, Riverside Community College, Riverside Community College-Moreno Valley Campus, University of California, Riverside (UCR).

## *Crisis Support System of Care (CSSOC)*

**Mental Health Urgent Cares (MHUC)**

The Voluntary MHUCs operate 24 hours a day, 7 days a week, providing clinical and psychiatric assessment, crisis intervention, and supportive therapy as well as peer-to-peer enriched engagement and support. The MHUCs serve individuals 18 years and older with the Desert and Mid-County MHUCs also serving adolescents 13 years and older. Individuals may stay at the facility up to 23 hours.

**Crisis Residential Treatment facilities (CRT)**

CRTs provide enriched recovery based peer-to-peer support and interventions with the goal of stabilizing clients in acute crises, thereby, eliminating or reducing the need for inpatient hospitalization. Individuals may stay at the facility for up to 14 days.

**Data Collection**

All Crisis responses were entered into the CSSOC log in the electronic health record. Data is linked to the RUHS-BH electronic health record for further analyses. MHUCs and CRT utilization data is derived from the RUHS-BH electronic health record admissions.

## *Mobile Crisis Response Teams (MCRT)*

Mobile Crisis Response Teams (MCRTs) provide community based mobile crisis support services in the three county regions (West, Mid-County, Desert) with the goal of decreasing law enforcement involvement and inpatient hospitalizations. Originally designed to provide crisis services to adults, the program added teams to provide services specifically for youth age 21 and younger. Each team is comprised of a Clinical Therapist II or Behavioral Health Specialist and a Mental Health Peer Support Specialist. MCRTs are responsible for assessing the individual's needs and providing crisis support with a focus on connecting individuals to outpatient and substance use services. Beginning in January 2024, MCRTs responded to request for crisis services 24 hours a day, 7 days a week.

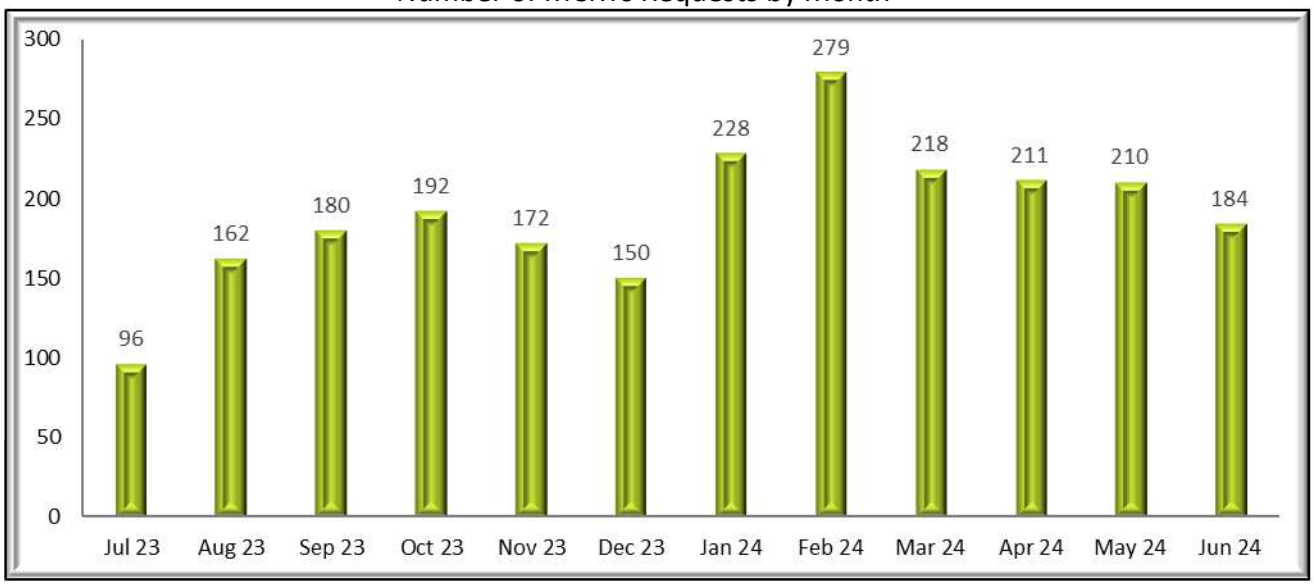
Requests for Service

MCRTs responded to 2,282 requests for mobile crisis response during the 2023/2024 fiscal year (July 1, 2023 through June 30, 2024). MCRTs responded to the most requests from the Mid-County region (n = 904). The average number of requests for MCRTs per month was 190.

| MCRT Crisis Requests 2,282 | |
|---|---|
| West | 843 |
| Mid-County | 863 |
| Desert | 576 |

Avg. Num. of Requests per Month
190

Number of MCRTs Requests by Month

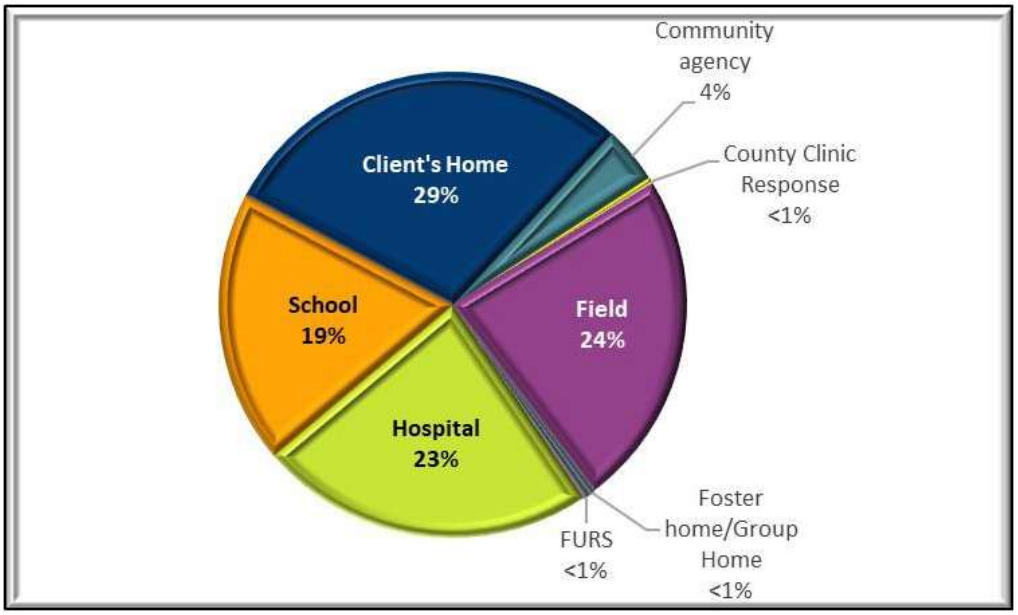


## *Mobile Crisis Response Teams (MCRT)*

MCRTs began primarily as a mobile crisis response to law enforcement requests for assistance with individuals experiencing a mental health crisis. MCRTs have expanded to include mobile crisis requests from hospital emergency departments, community agencies, group homes, and other community locations.

MCRTs responded to requests from client's homes (29%), the Field (24%) and Hospitals (23%) more than other locations. Field refers to locations in the community such as businesses and streets.

Location of Request




Response Times

The average response time for MCRTs requests was 1 hour and 10 minutes.

Avg. MCRT Response Time
1 Hour 10 minutes

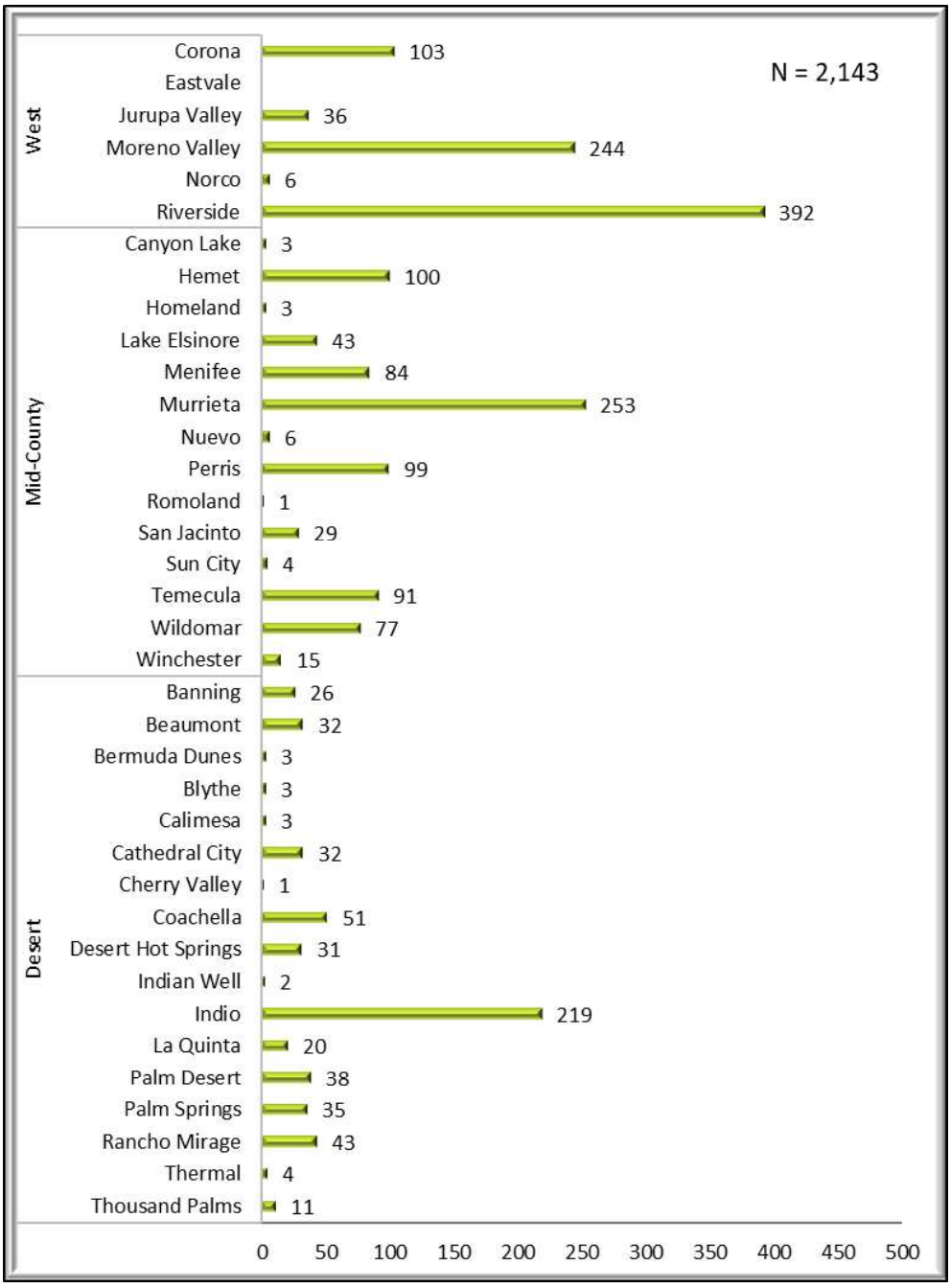
58% of responses were in an hour or less
89% of responses were within 2 hours
95% of responses were within 3 hours

## *Mobile Crisis Response Teams (MCRT)*

Cities and Regions

MCRTs received requests for service from multiple cities, through-out the county. The figure below provides the number of requests per city in each county region. In the Western region, the city of Riverside had the most requests for MCRTs (n = 392). In Mid-County, MCRTs received the most requests from Murrieta (n = 253). Finally, the Desert region received the most requests for MCRTs from Indio (n = 219). Data on city location was not reported for 126 crisis requests.

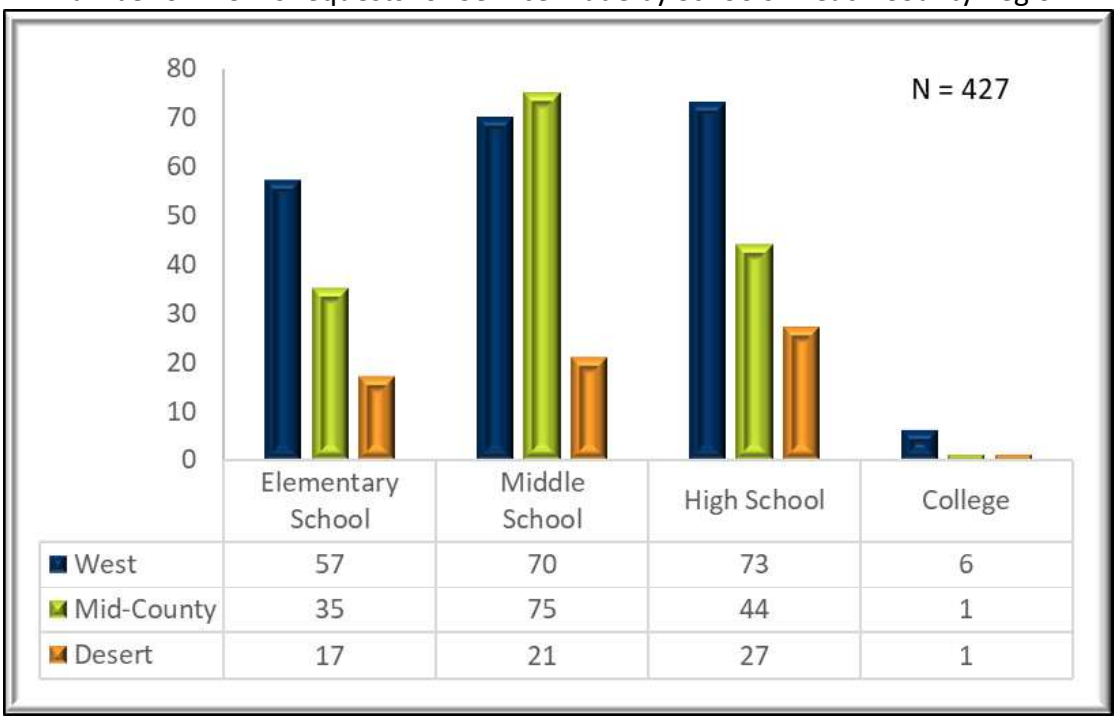
MCRTs Requests by City and County Region



## *Mobile Crisis Response Teams (MCRT)*

In an effort to decrease law enforcement involvement, MCRTs added teams in December 2018 to provide crisis service to youth age 21 and under at schools and other locations. Most requests for MCRTs at schools were made by school resource officers as schools preferred to make requests for MCRTs through their school resource officers rather than allowing other school staff to directly request MCRTs. The figure below shows the number of school requests MCRTs received in each county region during the 2023-2024 Fiscal Year. There was one request in the Western region from a charter school and one request in the Mid-County region from a private school. The Western region received the most requests for service at high schools, while the Mid-county region had the most requests for MCRT teams from middle schools.

Number of MCRTs requests for Service made by Schools in each County Region




| | Elementary School | Middle School | High School | College |
|---|---|---|---|---|
| West | 57 | 70 | 73 | 6 |
| Mid-County | 35 | 75 | 44 | 1 |
| Desert | 17 | 21 | 27 | 1 |

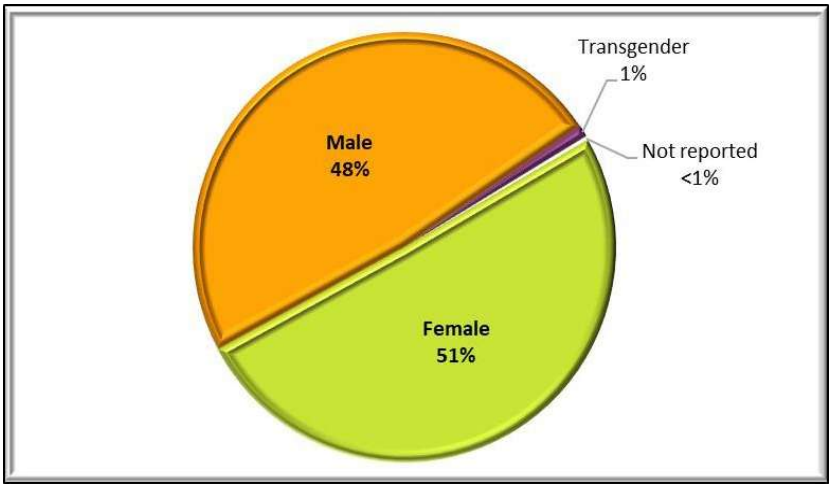
## *Mobile Crisis Response Teams (MCRT)*

Demographics

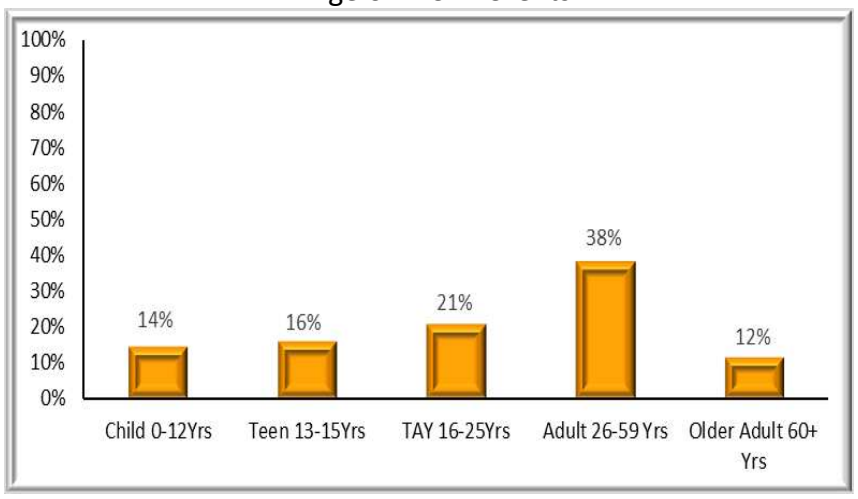
MCRTs served 2,012 individuals during the 2023/2024 fiscal year. Most individuals spoke either English (54%) or Spanish (2%). Language was not reported for 45% of individuals. Nine percent of individuals reported experiencing homelessness and 1.5% were Veterans.

MCRTs served more females (51%) than males (48%), with 1% of individuals identifying as transgender. Gender was not reported for 5 individuals.

Gender of MCRT Clients




Age of MCRT Clients




Over a third (38%) of clients were adults between the ages of 26 and 59 years of age. Age was not reported for 5 clients.

Hispanics/Latinos (44%) and White/ Caucasians (35%) were served the most by MCRTs.

Ethnicity of MCRT Clients

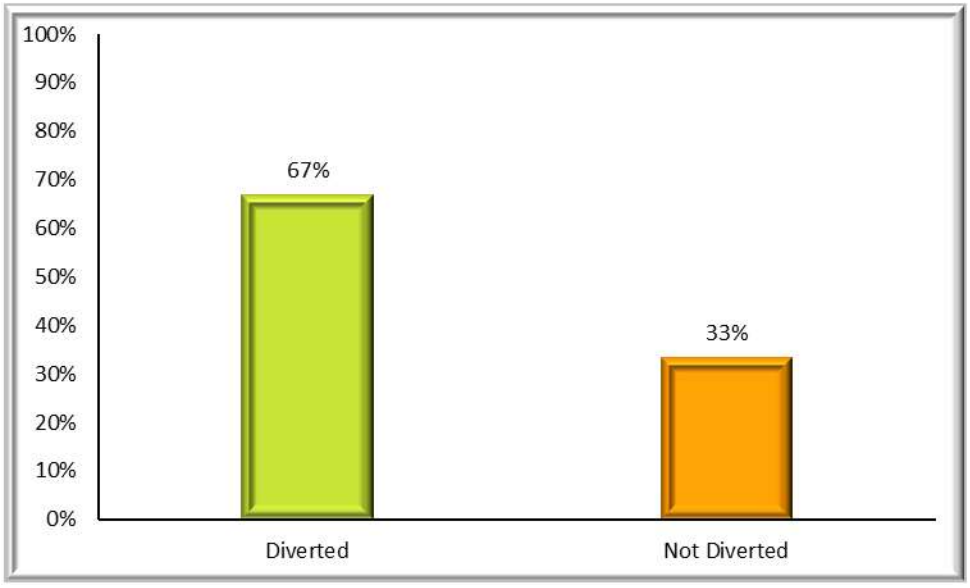
| Ethnicity | N | % |
|---|---|---|
| Am. Indian/Alaskan Native | 11 | 1% |
| Asian/Pacific Islander | 56 | 3% |
| Black/African American | 234 | 14% |
| Hispanic/Latino | 729 | 44% |
| Multi-Racial | 104 | 6% |
| White/Caucasian | 579 | 35% |
| Not reported | 299 | 18% |

## *Mobile Crisis Response Teams (MCRT)*

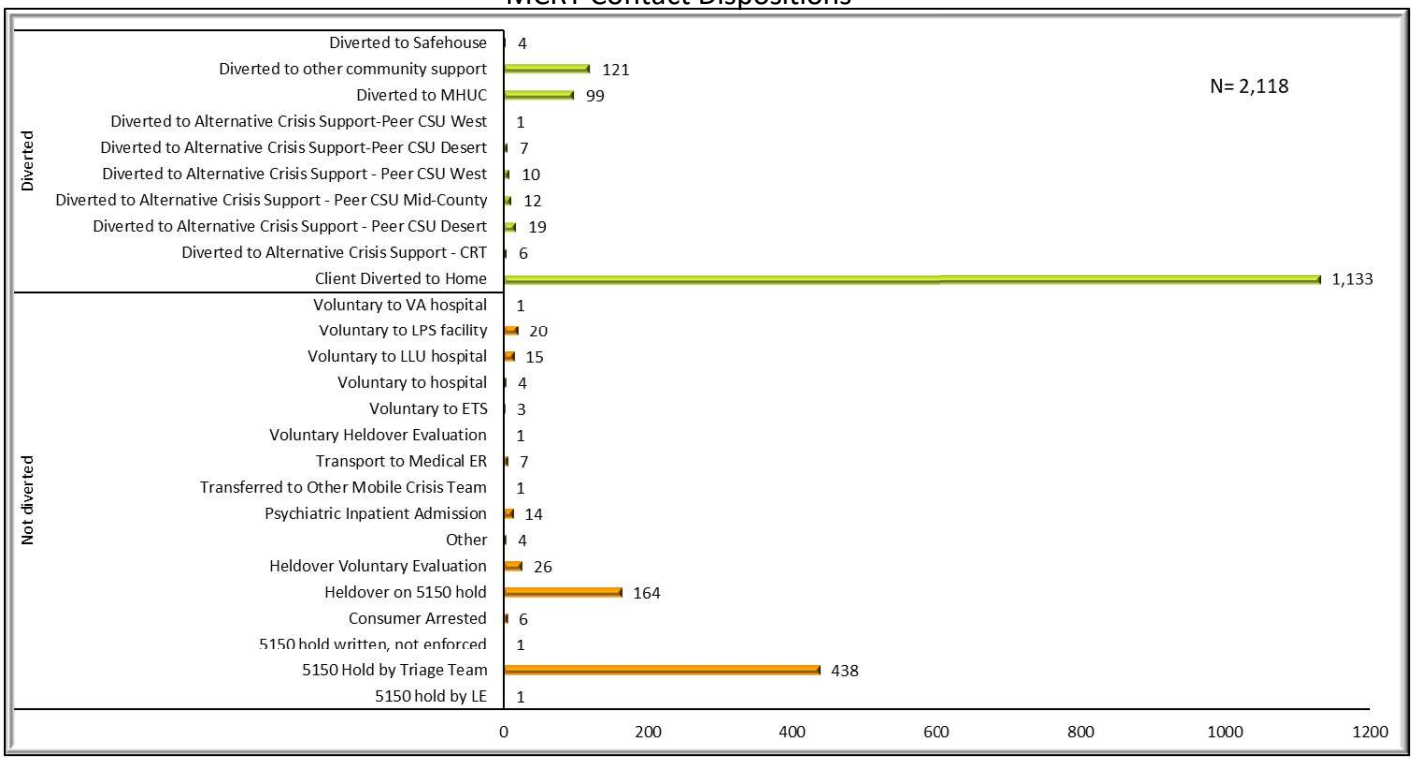
Diversion from Inpatient Admissions

Diversion from an inpatient admission was measured using the disposition of the crisis contact. A contact is considered diverted if the individual returns home, is sent to an MHUC, or is sent to an alternative crisis support. Non-crisis community supports included homeless shelters, emergency housing, and other social services. Contacts in which the client was unable or unwilling to interact with MCRTs (7%, n = 163) or that had a disposition of "Other" (0.1%, n = 3) or a disposition of "consumer arrested" (0.2%, n = 6) were excluded from the calculation of diversion rates. MCRTs were able to successfully divert 67% of crisis contacts in the field. The figure below provides the crisis disposition of MCRT contacts.

Diversion rates for MCRTs




MCRT Contact Dispositions



## *Mobile Crisis Response Teams (MCRT)*

Inpatient Admissions

Engagement in outpatient services should lessen the need for subsequent inpatient admissions. Contacts resulting in a 72 hour legal hold were not used in the calculation of inpatient admissions.
Eight percent (n = 158) of individuals had an inpatient admission within 60 days of contact with MCRTs. Some individuals (n = 28) had more than one admission within 60 days of MCRT contact.

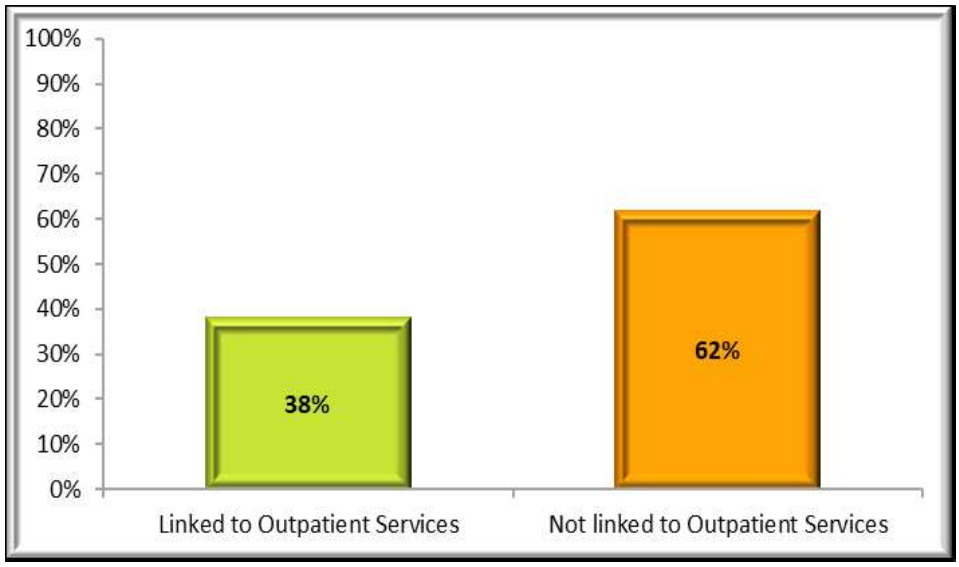
| Inpatient Admissions | N | % |
|---|---|---|
| Had at least one inpatient admission | 130 | 6% |
| Had more than one inpatient admission | 28 | 1% |
| Total Inpatient Admissions | 158 | 8% |

## *Mobile Crisis Response Teams (MCRT)*

Outpatient Service

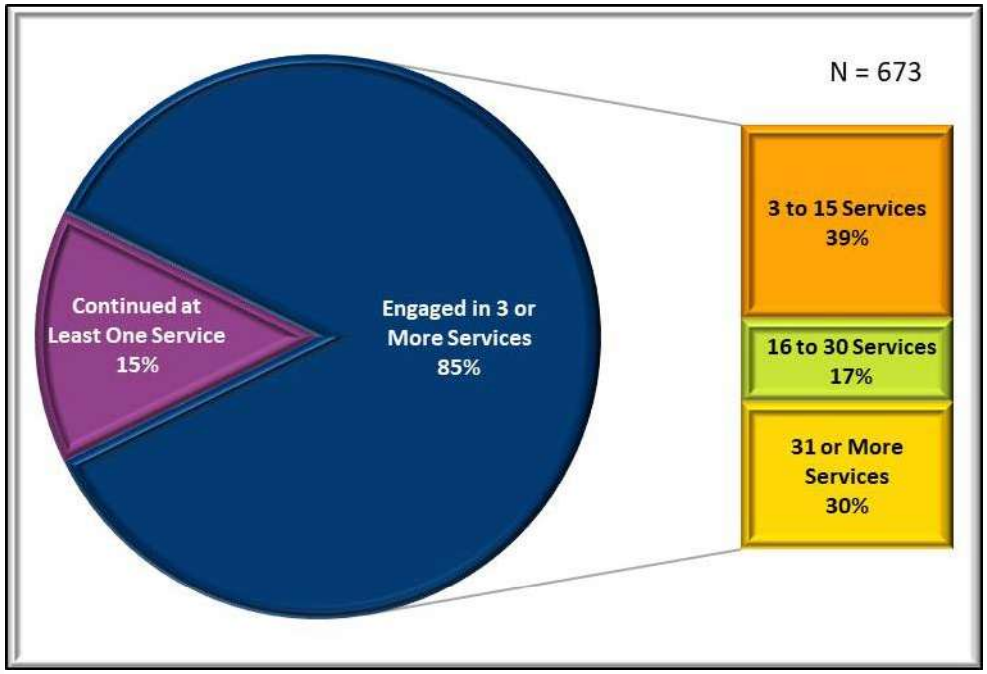
RUHS-BH service data was used to examine outpatient service. Clients were considered to be linked to outpatient services if they had an outpatient mental health, substance use, or youth short-term residential treatment program service record. Individuals who were recorded as being linked to a private provider or who had private insurance were not included in the analysis.

Linked to Outpatient Services




Over a third (38%, n = 673) of individuals served by MCRTs had an outpatient service after contact with teams. Some of these individuals (n = 348) had an outpatient service before having contact with MCRTs.

Engagement in Services



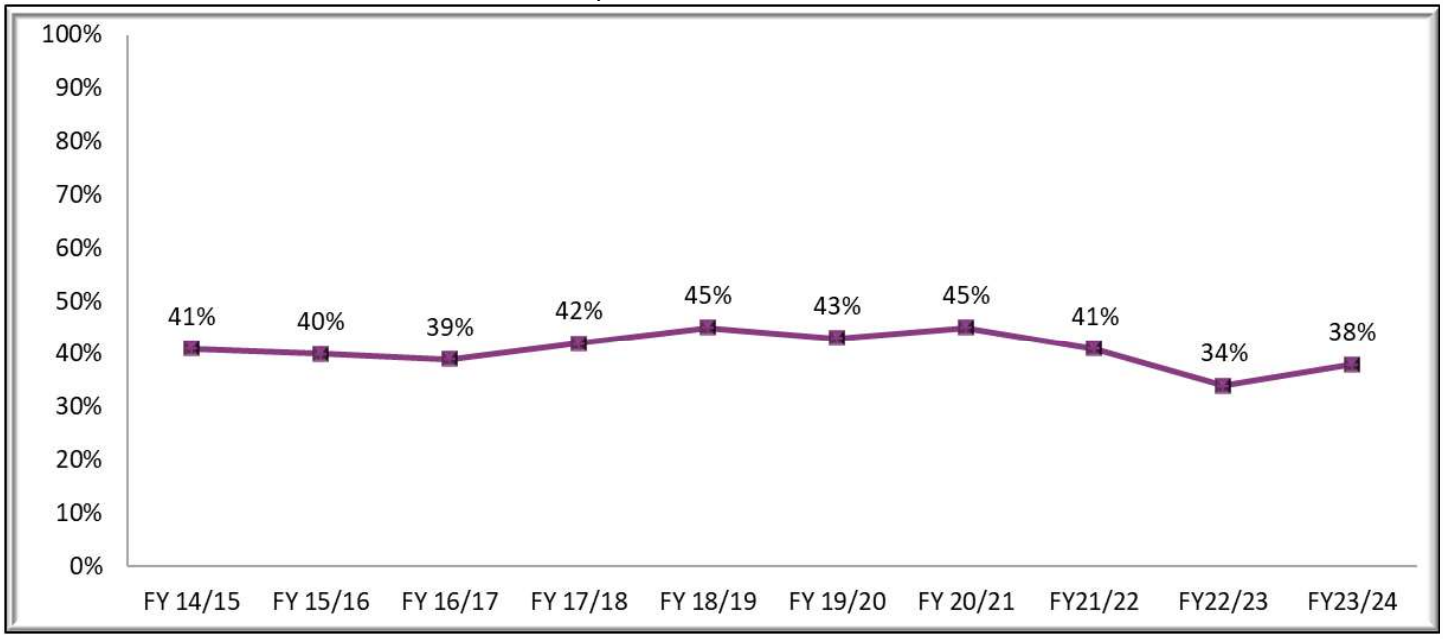

The majority (85%) of individuals linked to outpatient services engaged in three or more services. Over a third (39%) of MCRT clients who were linked to services participated in 3 to 15 services. For clients with 3 or more services, the average number of services was 36.

## *Mobile Crisis Response Teams (MCRT)*

Outpatient Admission Trends

The figure below provides the percentage of clients linked to outpatient services after contact with MCRTs for each fiscal year since the beginning of the Crisis program. MCRTs began serving clients in mid December 2014; therefore, the data for the 2014/2015 fiscal year is from December 18, 2014 through June 30, 2015. Individuals who were recorded as having private insurance were not included in the analysis.

Outpatient Admission Trends




Recidivism Rates

The table below provides the repeat crisis readmission rates at 15 days or less after first crisis contact and at 16 to 30 days after first crisis contact. Both have remained relatively low.

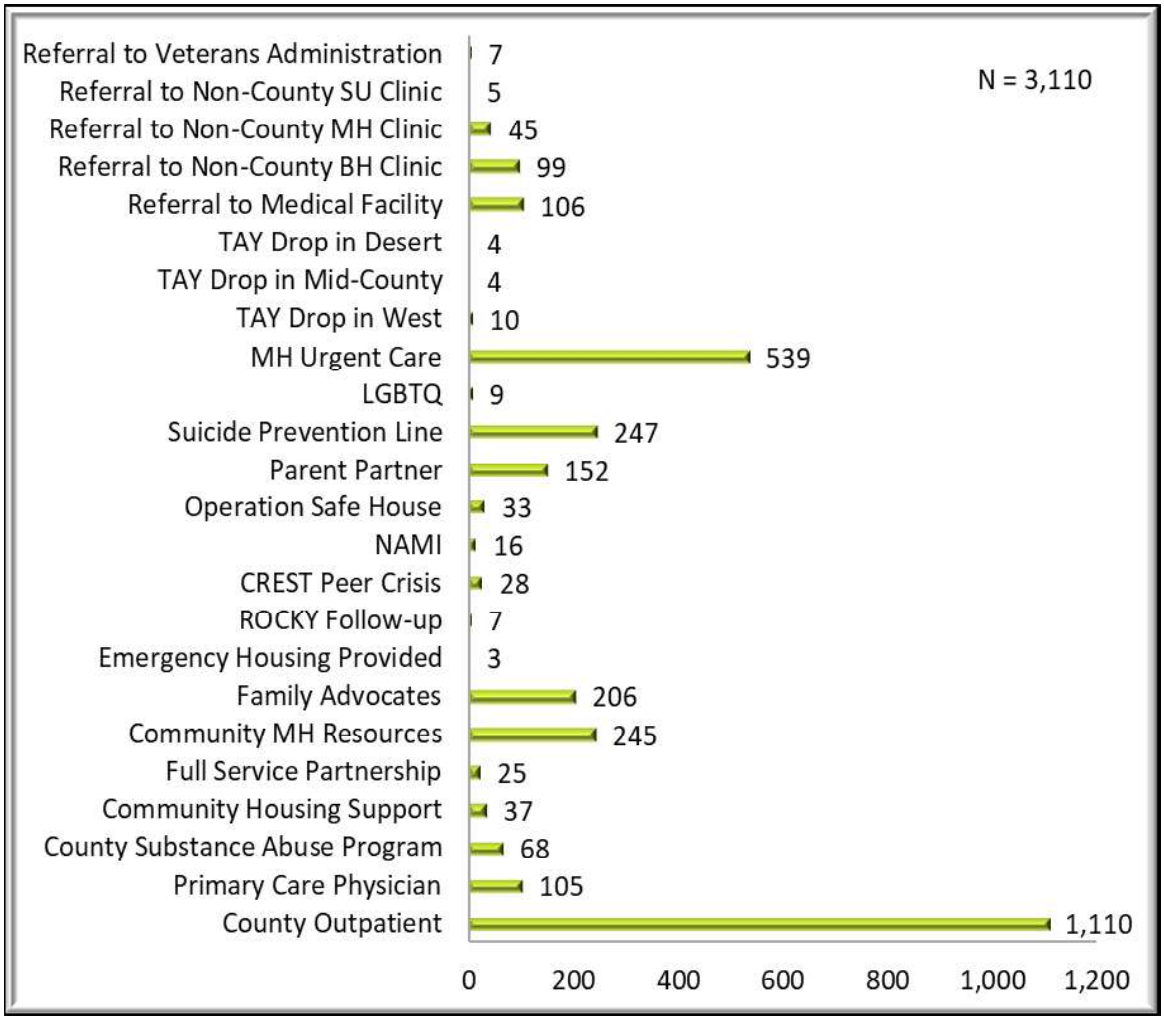
| MCRT Readmission Rates | |
|---|---|
| Days to Readmission | % |
| 0 to 15 Days | 4.95% |
| 16 to 30 Days | 2.41% |
| 0 to 30 Days | 7.36% |

## *Mobile Crisis Response Teams (MCRT)*

Service referrals

As part of crisis intervention, MCRTs provide individuals with referrals for various services each time teams have contact with a client. Individuals can receive multiple referrals for different services. MCRTs provided 3,110 referrals to 2,012 individuals.

Service Referrals



## *Mobile Crisis Management Teams (MCMT)*

Mobile Crisis Management Teams (MCMT) serve individuals who are at risk of a mental health crisis or who frequently utilize the crisis response system (e.g., emergency rooms or law enforcement) due to behavioral health needs. The MCMT teams consists of four staff members: Clinical Therapist, Behavioral Health Specialist II, Behavioral Health Specialist III, and Peer Support Specialist. Teams respond to requests from various entities in the county 24 hours a day/7 days a week and assess and intervene with individuals experiencing a mental health crisis. MCMTs provide intensive case management after the initial crisis contact and continued engagement for linkage to ongoing outpatient care. In addition, teams conduct intense, short-term, home-based case management and therapy, substance abuse services, linkage to residential services, and outreach to unengaged youth or adults who are at risk, homeless, or need services to prevent a mental heath crisis.

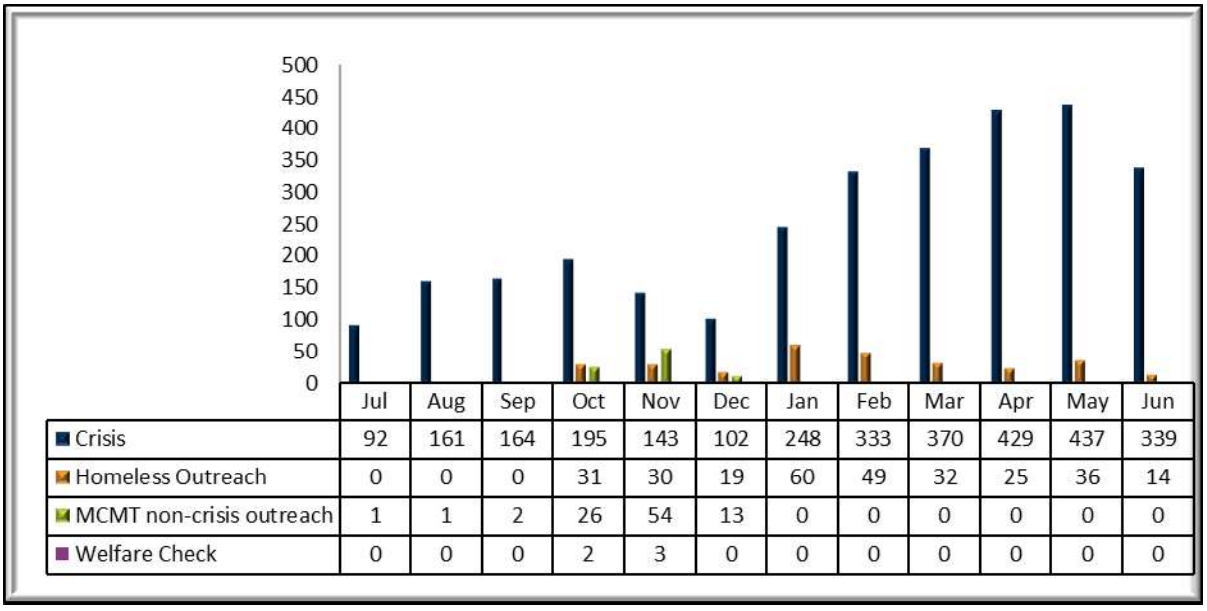
Requests for Service

MCMT began service in August of 2021. During the 2023/2024 fiscal year, 14 MCMT teams responded to 3,411 requests for service (including requests for Homeless Outreach, Non-Crisis Outreach, and Welfare Checks).

| MCMT Requests 3,411 | |
|---|---|
| Crisis | 3,013 |
| Homeless Outreach | 296 |
| MCMT Non-Crisis Outreach | 97 |
| Welfare Check | 5 |

The figure below provides the number of requests for MCMTs per month for each type of service (crisis, homeless outreach, welfare checks, non-crisis outreach) for the 2023-2024 fiscal year. MCMTs received an average of 284 request for service per month.

Number of Requests for MCMT teams per month



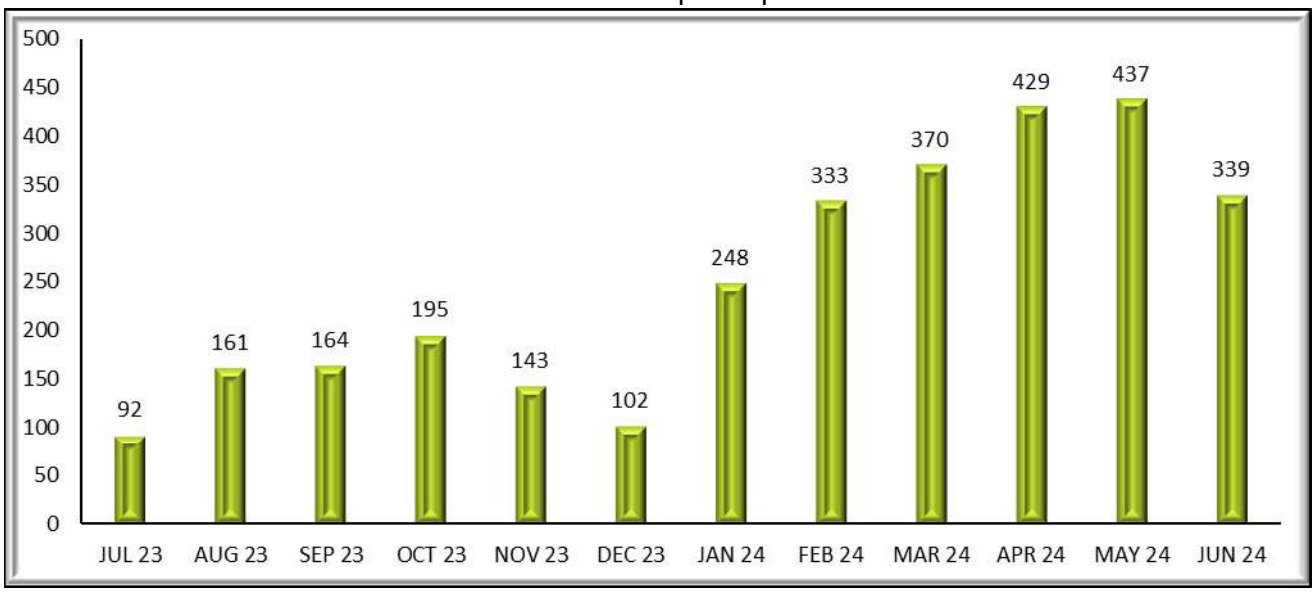

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Crisis | 92 | 161 | 164 | 195 | 143 | 102 | 248 | 333 | 370 | 429 | 437 | 339 |
| Homeless Outreach | 0 | 0 | 0 | 31 | 30 | 19 | 60 | 49 | 32 | 25 | 36 | 14 |
| MCMT non-crisis outreach | 1 | 1 | 2 | 26 | 54 | 13 | 0 | 0 | 0 | 0 | 0 | 0 |
| Welfare Check | 0 | 0 | 0 | 2 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

## *Mobile Crisis Management Teams (MCMT)*

Crisis Requests

MCMTs received 3,013 requests for Crisis Services during the 2023-2024 fiscal year. The average number of calls per month for Crisis Services for MCMTs was 251.

Number of Crisis Requests per Month




The table below provides the number of crisis requests received by each MCMT team.

MCMT Crisis Requests by Team

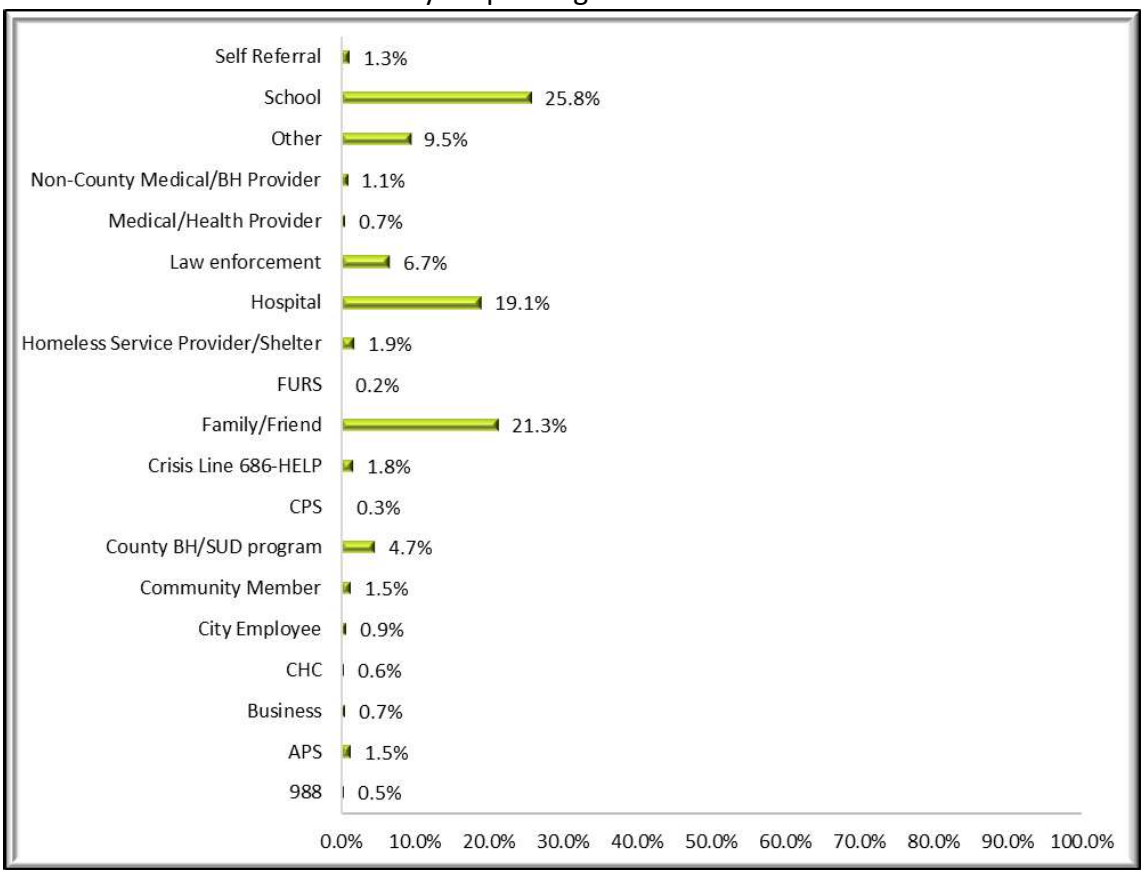
| MCMT Team | N | % |
|---|---|---|
| Banning MCMT | 242 | 8% |
| Blythe MCMT | 79 | 3% |
| Corona MCMT | 149 | 5% |
| DHS MCMT | 159 | 5% |
| Hemet MCMT | 235 | 8% |
| Indio MCMT | 211 | 7% |
| Jurupa Valley MCMT | 200 | 7% |
| Lake Els. MCMT | 156 | 5% |
| Menifee MCMT | 128 | 4% |
| Moreno Valley MCMT | 189 | 6% |
| Perris Mid-County MCMT | 279 | 9% |
| Riverside MCMT | 256 | 8% |
| Sycamore | 592 | 20% |
| Temecula MCMT | 138 | 5% |

## *Mobile Crisis Management Teams (MCMT)*

Request for Service

MCMT teams receive requests for crisis services from various entities through-out the county. The highest percentage of requests for MCMTs for crisis service came from Schools (25.8%), Family/Friends (21.%) and Hospitals (19.1%).

Entity Requesting Crisis Services

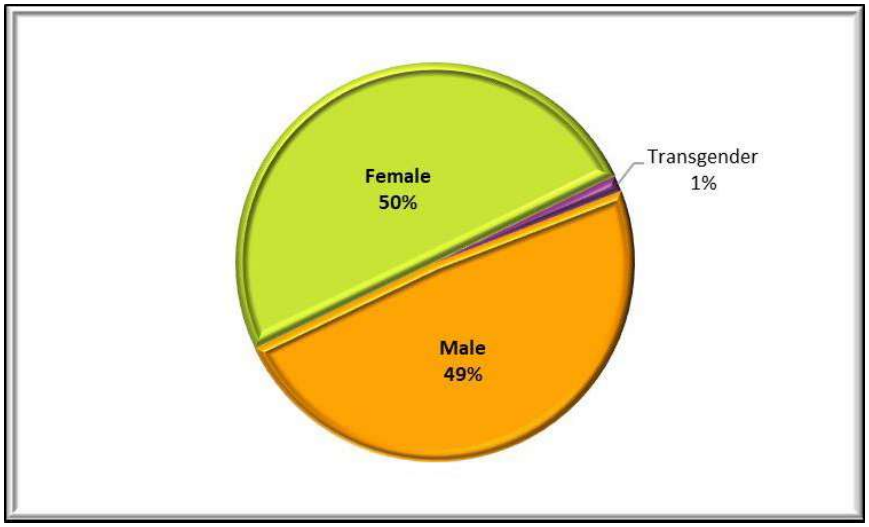


## *Mobile Crisis Management Teams (MCMT)*

Demographics for Crisis Requests

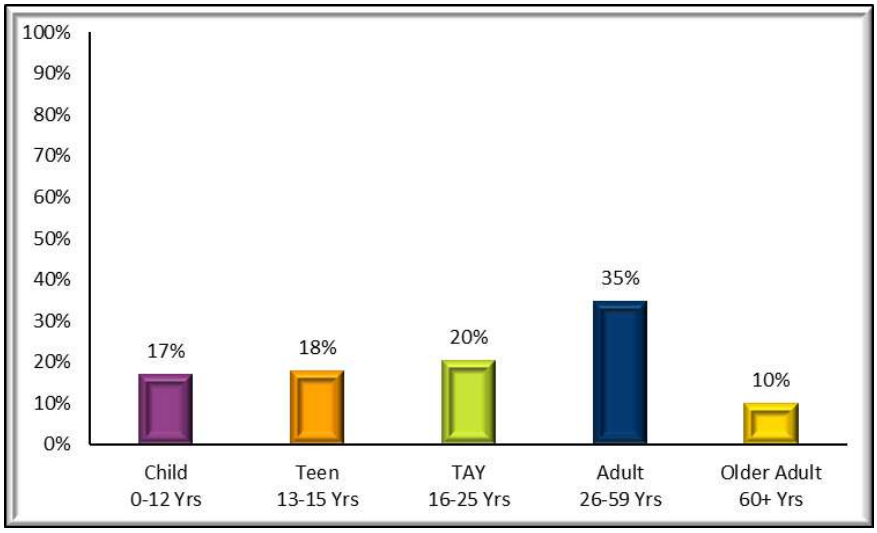
The demographics presented here are for clients who received Crisis services. Clients receiving Homeless Outreach, Welfare Checks, and MCMT Non-Crisis Outreach were excluded from these analyses. MCMT teams provided Crisis services to 2,556 during the 2023/2024 fiscal year.

Gender of Crisis MCMT clients




MCMTs provided crisis services to slightly more females (50%) than males (49%). Individuals identifying as transgender accounted for 1% of all MCMT crisis clients.

Age of Crisis MCMT clients




TAY Youth accounted for one-fifth (20%) of clients served by MCMT crisis teams. Adults (age 26 to 59 years of age) represented over a third (35%) of MCMT crisis clients.

Ethnicity of MCMT clients

| Ethnicity | N | % |
|---|---|---|
| Am. Indian/Alaska Native | 20 | 1% |
| Asian/Pacific Islander | 83 | 3% |
| Black/African American | 335 | 13% |
| White/Caucasian | 856 | 33% |
| Hispanic/Latinx | 980 | 38% |
| Multi-Racial | 275 | 11% |
| Not Reported | 7 | - |

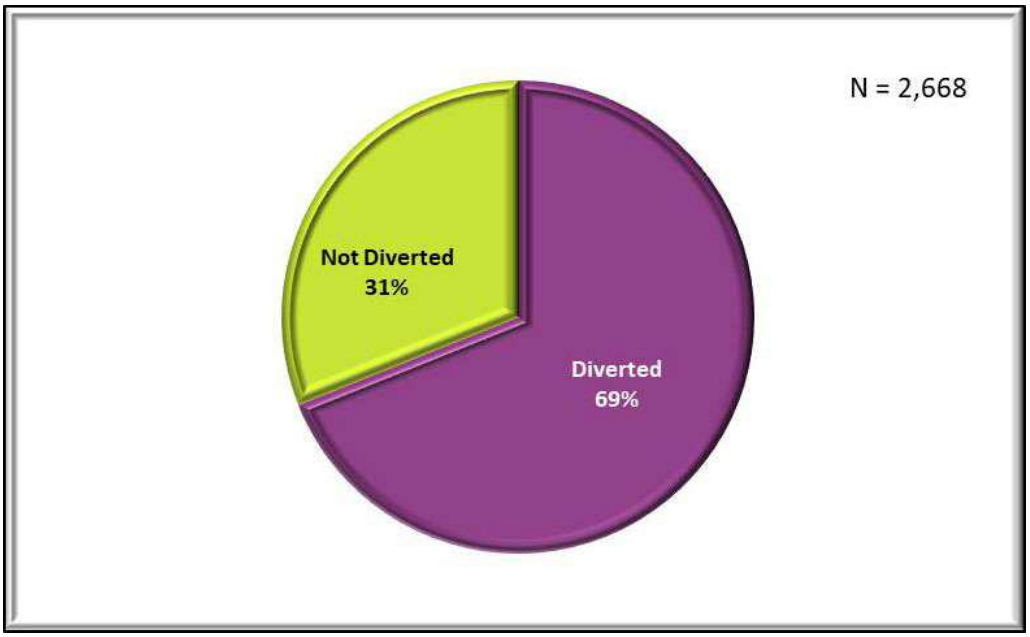
Hispanics/Latinx (38%) and White/Caucasians (33%) were served the most by MCMT teams. Individuals experiencing homelessness accounted for 13% of crisis clients, while 1% of clients were Veterans.

## *Mobile Crisis Management Teams (MCMT)*

Crisis Diversions

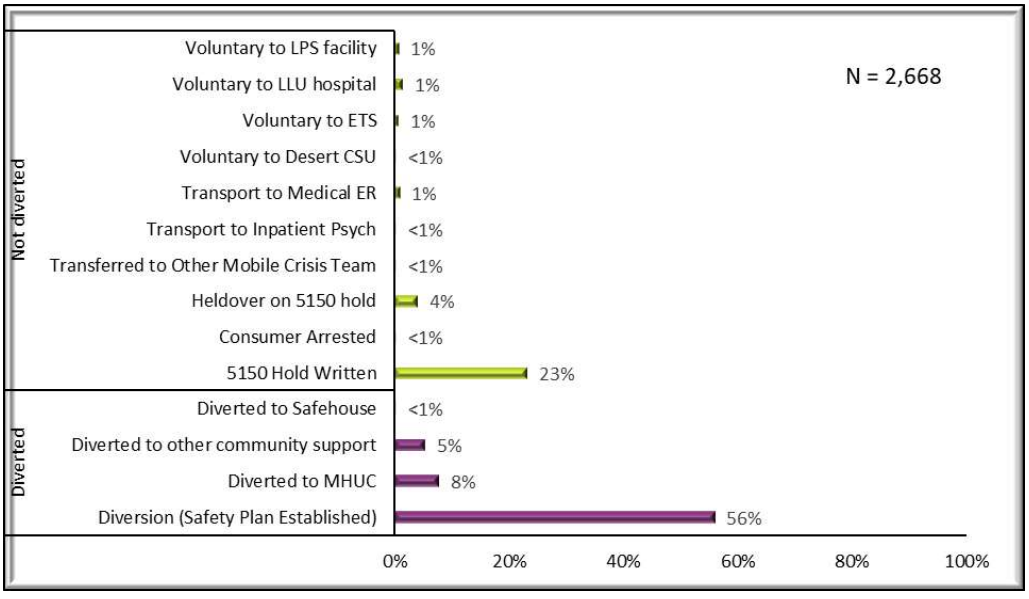
MCMTs divert individuals from inpatient admissions. The figure below provides the diversion rates for requests for crisis service. Requests in which the consumer refused services (6%, n = 177) or had a disposition of "Other" (6%, n = 168) were excluded from diversion rate calculations. Individuals are considered diverted if they were sent home with a safety plan , sent to an MHUC, or sent to some other community support.

Percentage of Crisis Requests Diverted




MCMTs were able to divert 69% of crisis requests from an inpatient admission.

Disposition of Crisis Requests



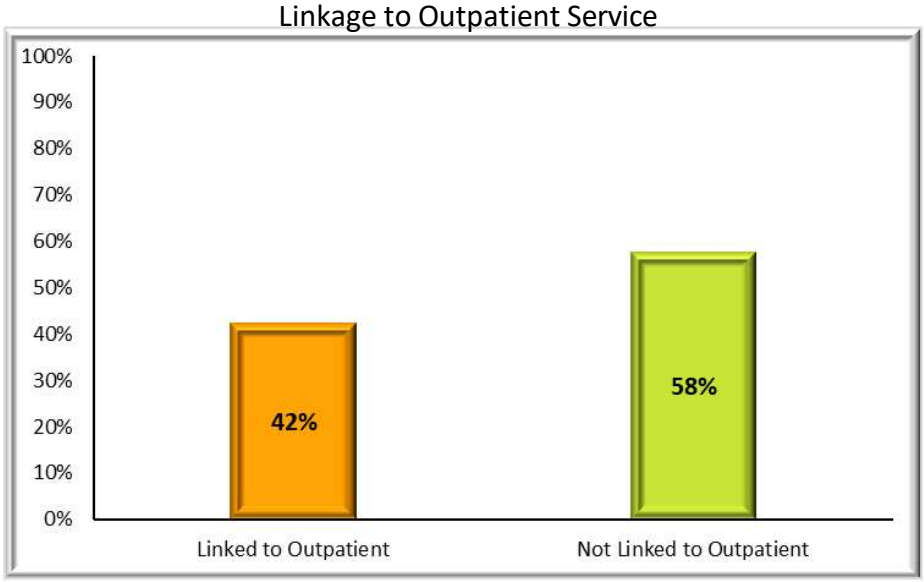

The figure to the left provides the dispositions of MCMT crisis requests. Individuals either were diverted with safety plan, diverted to MHUC, diverted to other community support, or diverted to safehouse.

## *Mobile Crisis Management Teams (MCMT)*

Linkage to Outpatient Services

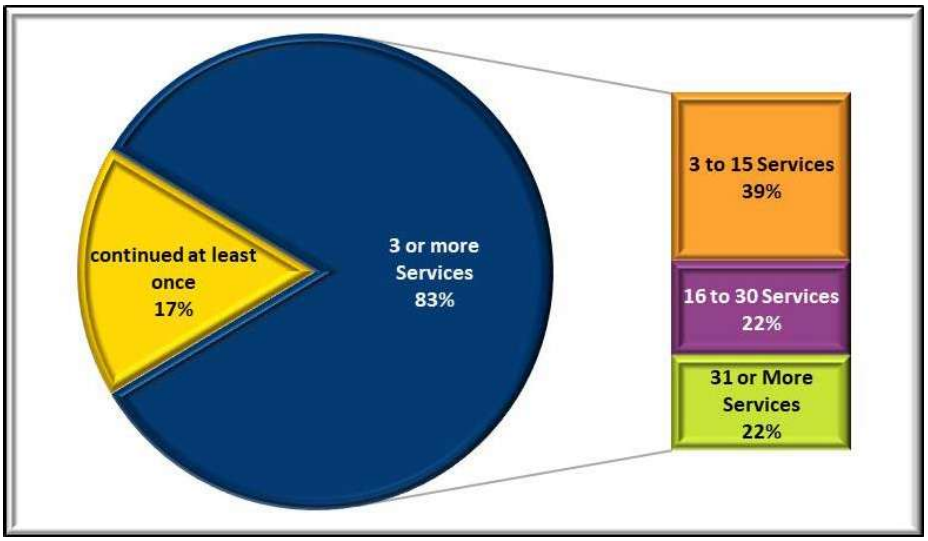
In addition to diverting individuals from an inpatient admission, MCMTs connect individuals to outpatient services. RUHS-BH service data was used to examine service usage after contact with MCMTs. Clients were considered to be linked to outpatient services if they had an outpatient, substance use, or youth short-term residential program service record. Individuals who were recorded as having private insurance were excluded from these analyses.

Linkage to Outpatient Service




Forty-two percent (42%) of individuals served by MCMTs had an outpatient service after contact with teams. Some of these individuals (n = 421) were participating in outpatient services prior to their contact with teams.

Engagement in Services




For those MCMT clients with an outpatient service, 83% had three or more services. Over a third (39%) participated in 3 to 15 services. For clients with 3 or more services, the average number of services was 25.

Readmission Rates for MCMT

| Days to Readmission | % |
|---|---|
| 0 to 15 Days | 7.33% |
| 16 to 30 Days | 2.12% |
| 0 to 30 Days | 9.46% |

Recidivism

The table to the left provides the repeat crisis encounter rates at less than 15 days after first crisis contact and at 16 to 30 days after first contact with MCMT teams.

## *Community Behavioral Health Assessment Teams (CBAT)*

Community Behavioral Health Assessment Teams (CBAT) respond to law enforcement calls involving individuals experiencing mental health issues in the community. The purpose of the teams is to divert those individuals to community and behavioral health services. Teams consist of a specially trained law enforcement officer, who provides safety and law enforcement expertise, and a RUHS-BH Clinical Therapist II, who assesses the client's behavior.

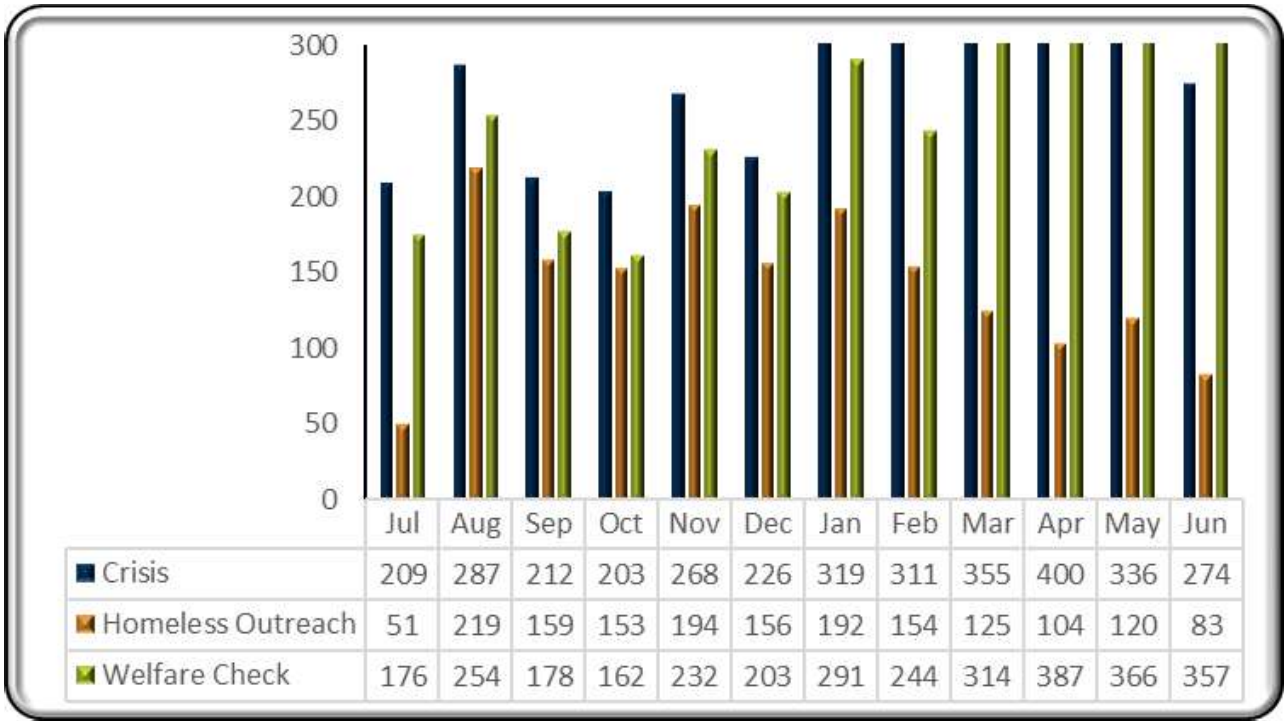
Requests for Service

During the 2023/2024 fiscal year, 18 CBAT teams responded to 8,274 requests for service (including requests for Homeless Outreach and Welfare Checks).

| CBAT Requests 8,274 | |
|---|---|
| Crisis | 3,400 |
| Homeless Outreach | 1,710 |
| Welfare Check | 3,164 |

Avg. Number of Calls per Month
690

Number of requests for CBAT teams per Month




| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Crisis | 209 | 287 | 212 | 203 | 268 | 226 | 319 | 311 | 355 | 400 | 336 | 274 |
| Homeless Outreach | 51 | 219 | 159 | 153 | 194 | 156 | 192 | 154 | 125 | 104 | 120 | 83 |
| Welfare Check | 176 | 254 | 178 | 162 | 232 | 203 | 291 | 244 | 314 | 387 | 366 | 357 |

## *Community Behavioral Health Assessment Teams (CBAT)*

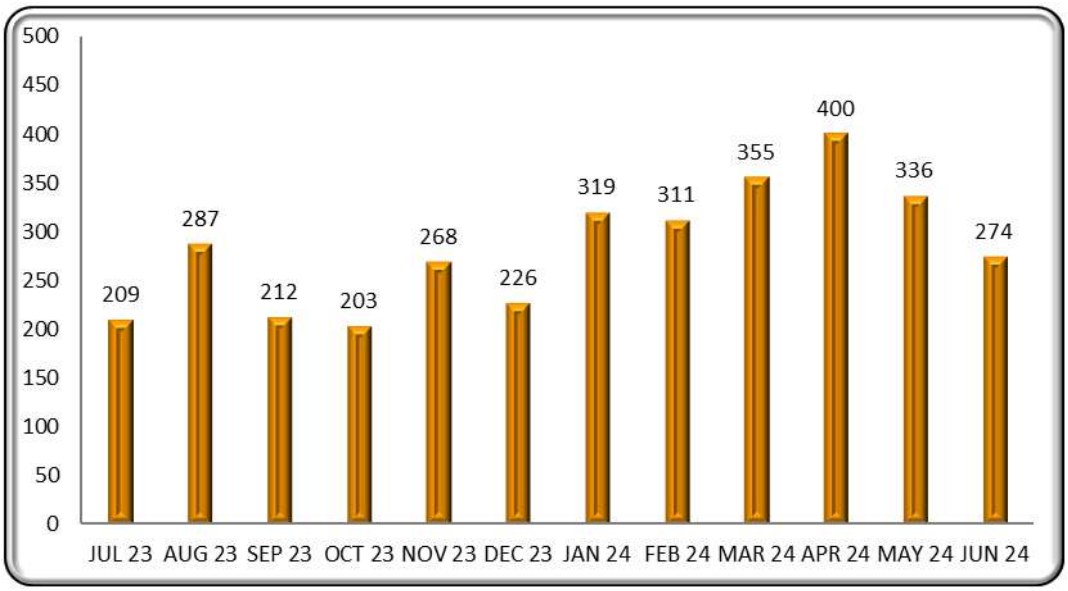
Crisis Requests

CBATs received 3,400 requests for Crisis Services during the 2023-2024 fiscal year. The average number of requests per month for Crisis Services for CBAT was 283.

| Avg. Number of CBAT Crisis Requests per Month |
|---|
| 283 |

| CBAT Requests for Crisis Service | 3,400 |
|---|---|
| West | 1,184 |
| Mid-County | 1,760 |
| Desert | 456 |

Number of requests for Crisis Services




CBAT Crisis Requests by Team

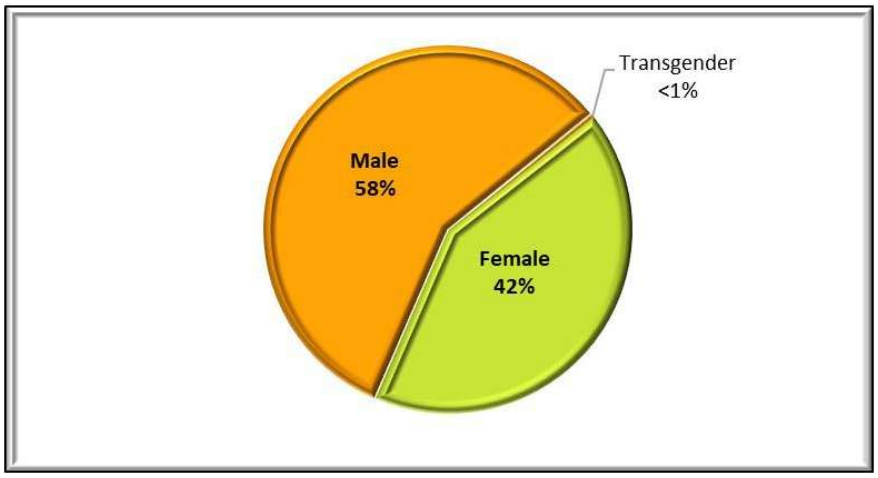
| CBAT Team | N | % |
|---|---|---|
| Banning PD/Beaumont PD/Cabazon Sheriff/Cathedral City | 54 | 2% |
| Corona PD | 176 | 5% |
| Hemet PD | 478 | 14% |
| Hemet Sheriff | 181 | 5% |
| Indio PD | 74 | 2% |
| Jurupa Sheriff | 347 | 10% |
| Lake Elsinore Sheriff | 288 | 8% |
| Menifee PD | 290 | 9% |
| Moreno Valley Sheriff | 361 | 11% |
| Murrieta PD | 195 | 6% |
| Palm Desert Sheriff | 176 | 5% |
| Perris Sheriff | 128 | 4% |
| Riverside PD | 300 | 9% |
| Temecula Sheriff | 200 | 6% |
| Thermal Sheriff | 152 | 4% |

## *Community Behavioral Health Assessment Teams (CBAT)*

Demographics

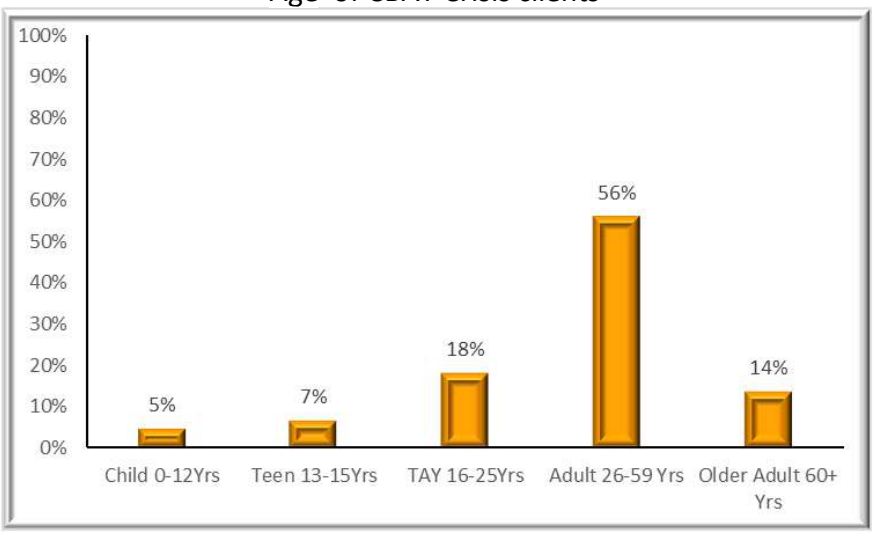
CBATs provided crisis services to 2.861 individuals during the 2023/2024 fiscal year. The demographics presented here are for individuals who received crisis services, all other calls were excluded.

Gender of CBAT Crisis clients




CBAT teams served more males (58%) than females (42%). Less than 1% of individuals (n=8) served by CBAT teams identified as transgender.

Age of CBAT Crisis clients




The majority of CBAT crisis clients (56%) were adults, age 26 to 59 years. Almost a fifth of clients (18%) served by CBAT teams were TAY age (16 to 25 years). Age was not reported for 3 clients.

Ethnicity of CBAT Crisis clients

| Ethnicity | N | % |
|---|---|---|
| Am. Indian/Alaska Native | 20 | 1% |
| Asian/Pacific Islander | 87 | 3% |
| Black or African American | 419 | 15% |
| Caucasian | 1,177 | 41% |
| Hispanic or Latinx | 989 | 35% |
| Multi-Racial | 153 | 5% |
| Not reported | 16 | 1% |

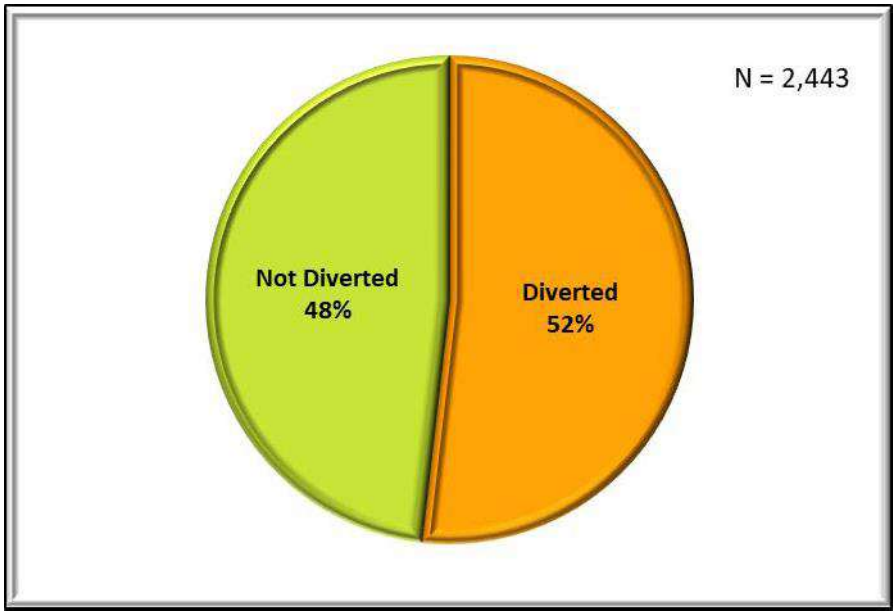
The table to the left provides the ethnicity of CBAT clients. Caucasians (41%), Hispanics/Latinx (35%), and Blacks/African-Americans (15%) were served the most. One fifth (20%) of CBAT crisis clients were reported as experiencing homelessness, while 3% of clients were Veterans.

## *Community Behavioral Health Assessment Teams (CBAT)*

Crisis Diversions

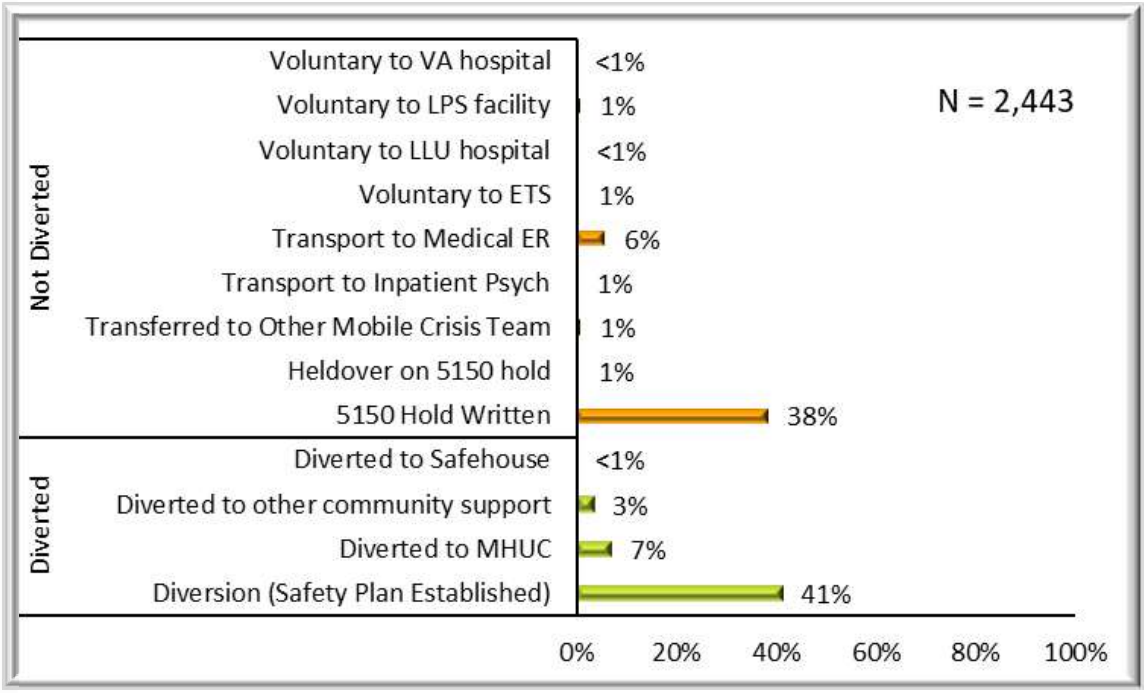
CBATs divert individuals from inpatient admissions. The figures below provide the percentage diverted as well as of the disposition of CBAT crisis contacts. Homeless outreach and welfare checks were excluded from these analyses. Consumers who refused service (12%, n = 412) or who were arrested (10% n = 341) were also excluded from the analyses. Individuals were considered diverted if they were returned home with a safety plan, sent to the MHUC, safehouse, or other community supports.

Percentage of Crisis Requests Diverted




CBATs were able to divert 52% of Crisis requests.

Disposition of Crisis Requests



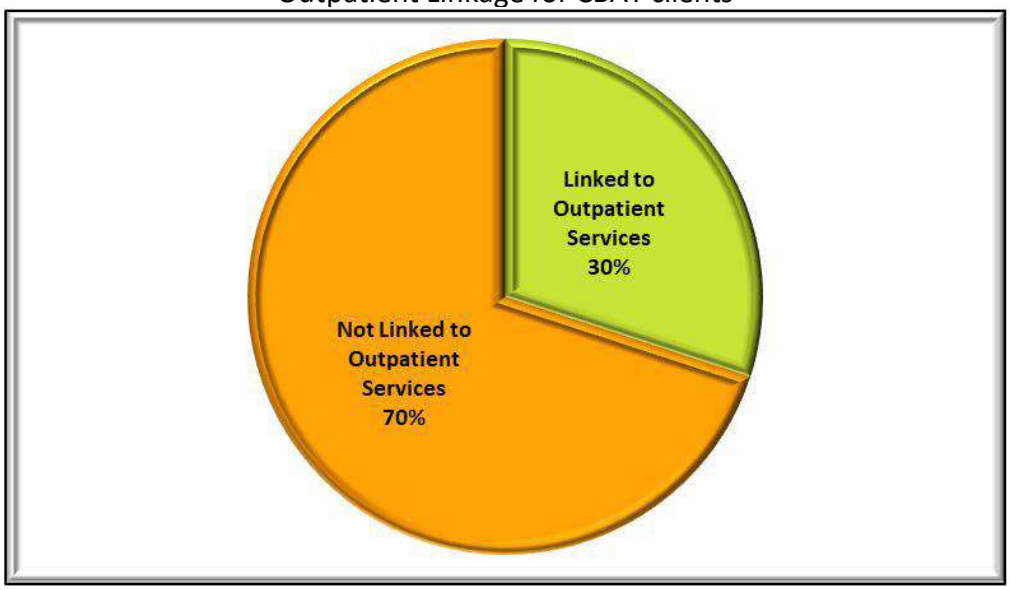

The figure to the left provides the crisis dispositions.

## *Community Behavioral Health Assessment Teams (CBAT)*

Linkage to Outpatient Services

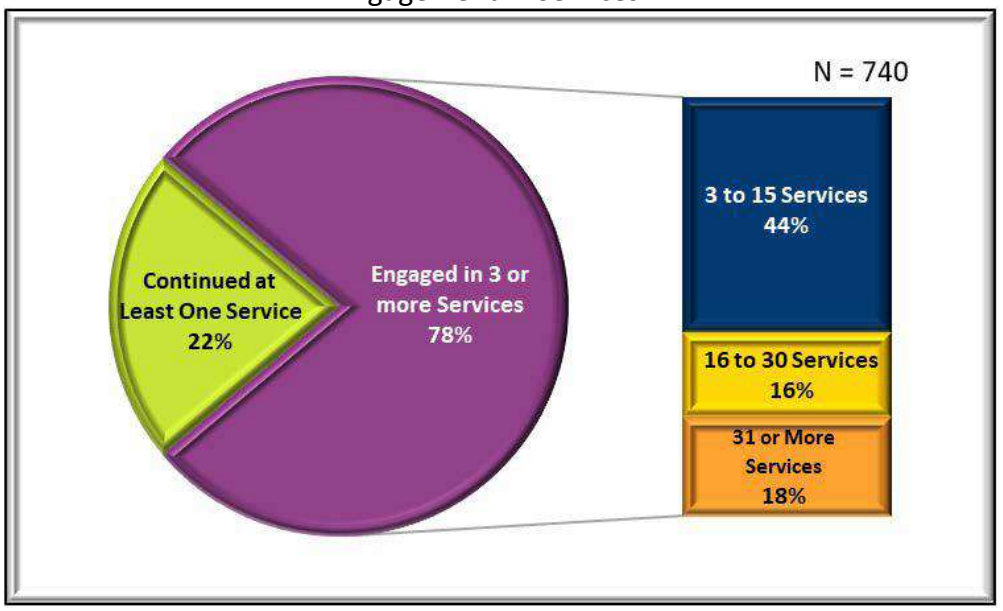
In addition to diverting individuals from inpatient admissions, CBAT teams connect individuals with outpatient services. RUHS-BH service data was used to examine outpatient service after contact with CBAT teams. Clients were considered linked to outpatient services if they had an outpatient, substance use, or youth short-term residential program service record. Individuals who were recorded as having private insurance were excluded from these analyses.

Outpatient Linkage for CBAT clients




Thirty percent (30%) of individuals served by CBAT teams were linked to outpatient services after contact with teams. Some of these individuals (n = 372) were already participating in outpatient services before having contact with CBAT teams.

Engagement in Services




The majority (78%) of CBAT clients linked to outpatient services engaged in three or more services. For clients with 3 or more services, the average number of services was 23.

Readmission Rates for CBAT

| Days to Readmission | % |
|---|---|
| 0 to 15 Days | 8.67% |
| 16 to 30 Days | 2.90% |
| 0 to 30 Days | 11.57% |

Recidivism

The table to the left provides the recidivism rates at less than 15 days after first crisis contact and at 16 to 30 days after first contact with CBATs.

## *Community Assessment and Transport Team (CATT)*

The Community Assessment and Transport Team (CATT) pairs a RUHS-BH Clinical Therapist with an EMT American Medical Response (AMR) to respond to individuals experiencing a mental health crisis in the City of Hemet. The team provides mental health assessment, resource referrals, and transportation when necessary to mental health and/or substance use facilities as well as to shelters with the goal of helping individuals who are dealing with mental health and/or substance issues.

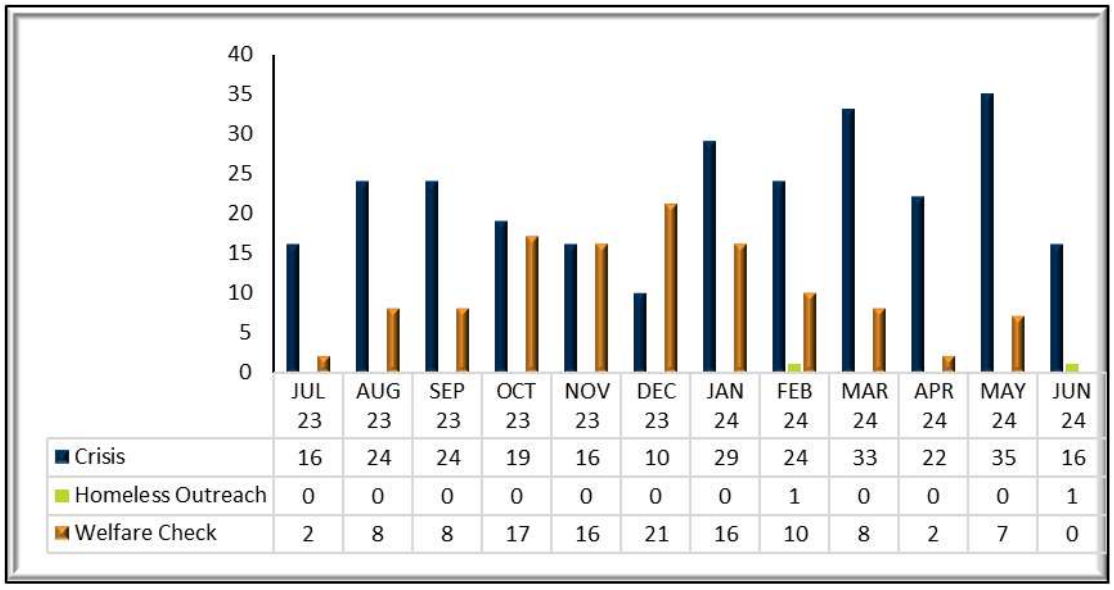
Requests for Service

During the 2023-2024 fiscal year CATT responded to 385 requests for service.

| CATT Requests 385 | |
|---|---|
| Crisis | 74 |
| Homeless Outreach | 1 |
| Welfare Check | 41 |

Avg. Number of Calls per month
32

Number of requests for CATT teams per Month




| | JUL 23 | AUG 23 | SEP 23 | OCT 23 | NOV 23 | DEC 23 | JAN 24 | FEB 24 | MAR 24 | APR 24 | MAY 24 | JUN 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Crisis | 16 | 24 | 24 | 19 | 16 | 10 | 29 | 24 | 33 | 22 | 35 | 16 |
| Homeless Outreach | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 |
| Welfare Check | 2 | 8 | 8 | 17 | 16 | 21 | 16 | 10 | 8 | 2 | 7 | 0 |

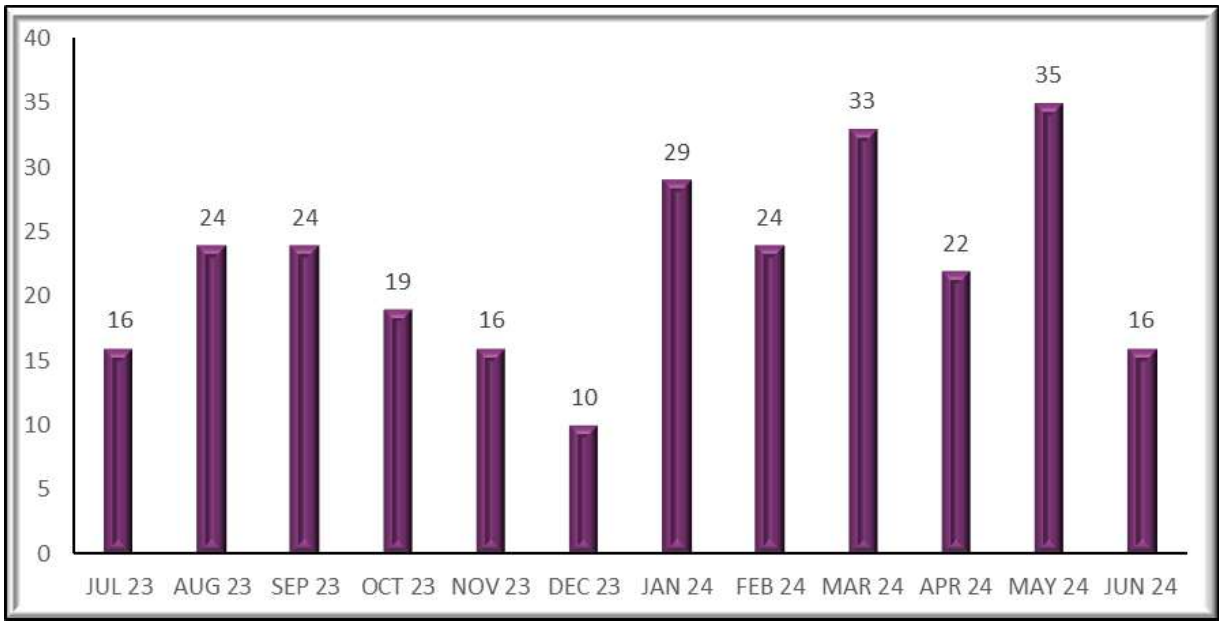
## *Community Assessment and Transport Team (CATT)*

Crisis Requests

CATT received 268 requests for Crisis Services during the 2023-2024 fiscal year. The average number of calls per month for Crisis Services for CATT was 22.

| Total Number of Crisis Calls |
| --- |
| 268 |

Number of requests for Crisis Services

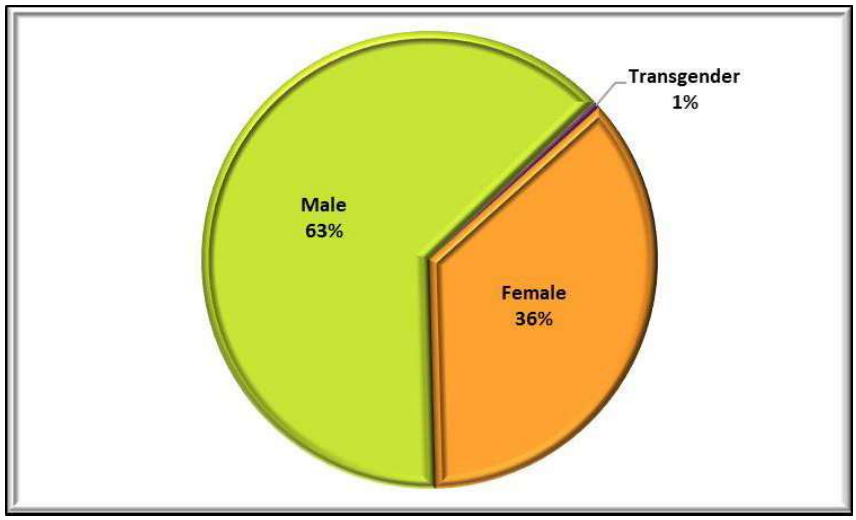


## *Community Assessment and Transport Team (CATT)*

Demographics

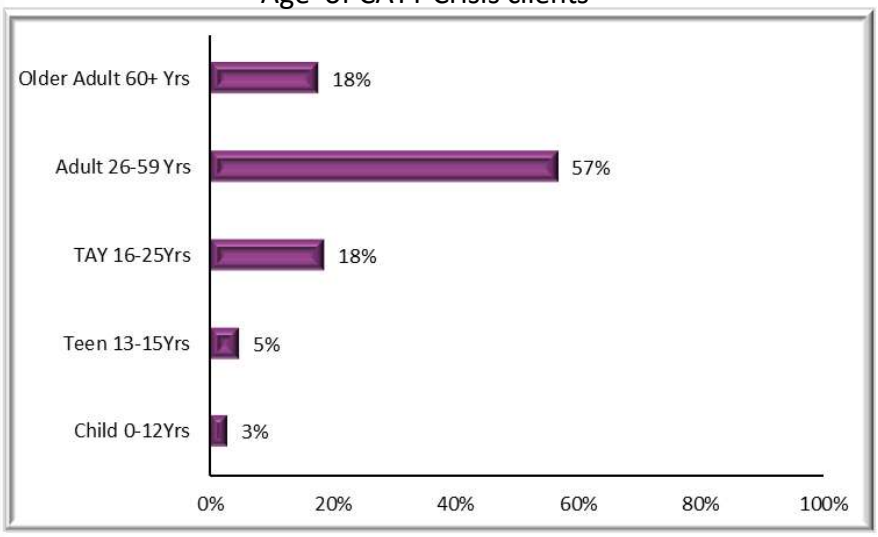
CATT provided crisis services to 218 individuals during the 20232/2024 fiscal year. The demographics presented here are for individuals who received crisis services, all other contacts were excluded.

Gender of CATT Crisis clients




CATT provided crisis services to more males (63%) than females (36%).

Age of CATT Crisis clients




The majority of clients served by CATT (57%) were adults (age 26 to 59 years of age).

Ethnicity of CATT Crisis clients

| Ethnicity | N | % |
|---|---|---|
| Am. Indian/Alaska Native | 1 | 0.5% |
| Asian/Pacific Islander | 1 | 0.5% |
| Black/African American | 22 | 10.1% |
| White/Caucasian | 86 | 39.4% |
| Hispanic/Latinx | 85 | 39.0% |
| Multi-Racial | 23 | 10.6% |
| Not Reported | 1 | 0.5% |

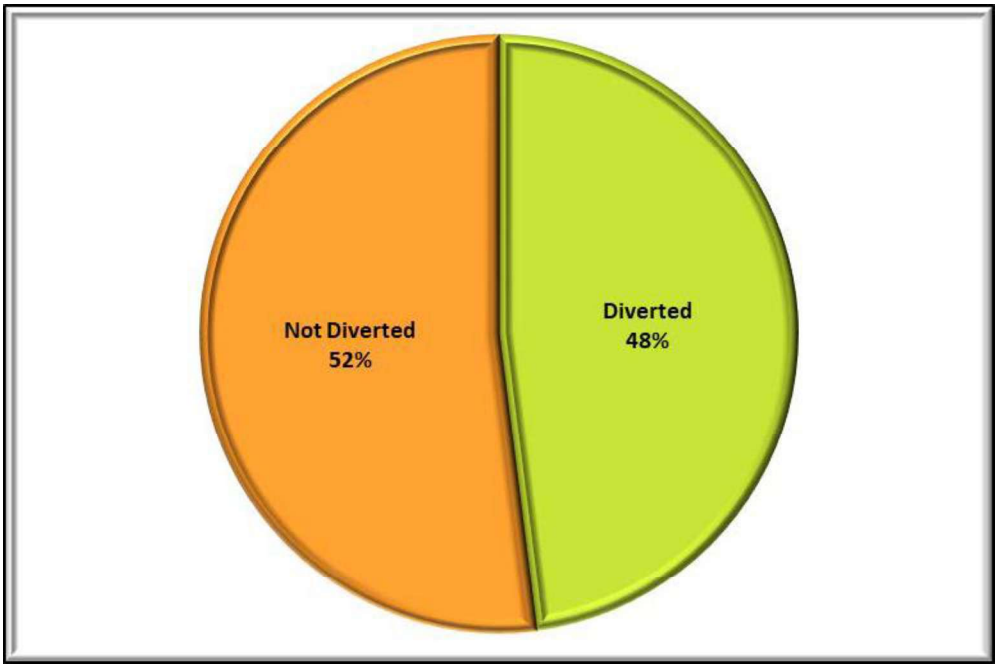
Hispanics/Latinx (39.0%) and White/Caucasians (39.4%) were served the most by the CATT team. Individuals experiencing homelessness accounted for 7.8% of crisis clients, while 1.4% of clients were Veterans.

## *Community Assessment and Transport Team (CATT)*

Diversion from an Inpatient Admission

The CATT team diverts individuals from inpatient admissions. The figures below provide the percentage diverted as well as of the disposition of CATT crisis calls. Homeless outreach and welfare checks were excluded from these analyses. Consumers who refused service (7%, n = 5) were also excluded from the analyses. Individuals were considered diverted if they were returned home with a safety plan, were sent to the MHUC, or other community support.

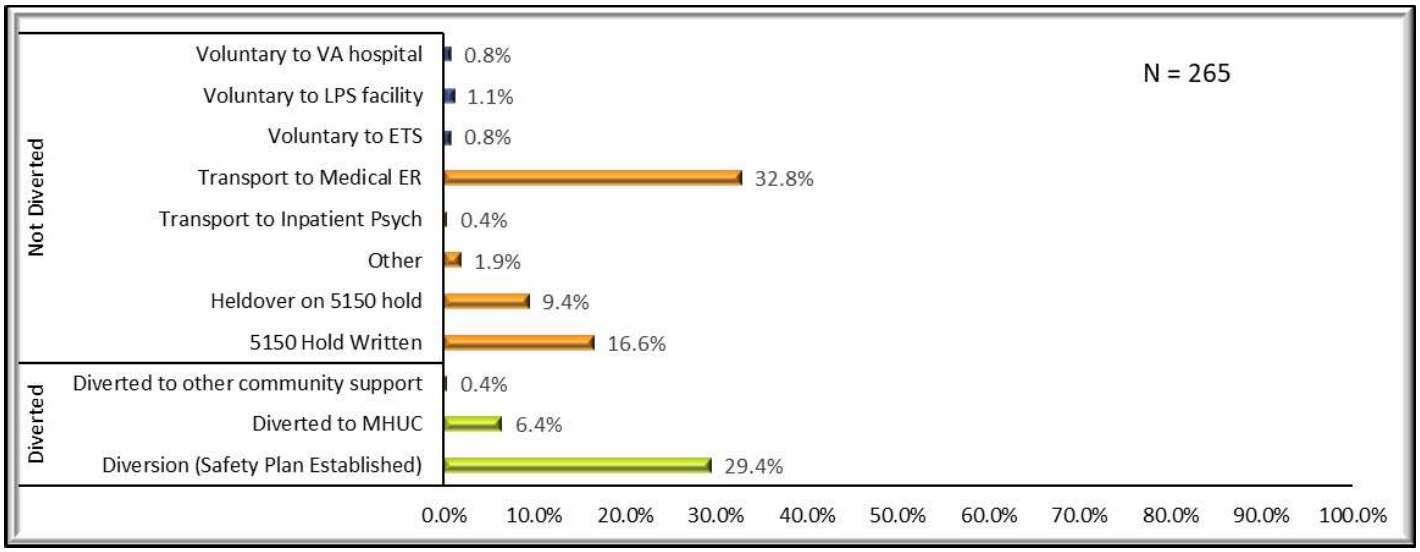
Percentage of Crisis Requests Diverted




CATT was able to divert 48% of Crisis calls.

The figure below provides the dispositions for crisis contacts.

Disposition of Crisis Requests

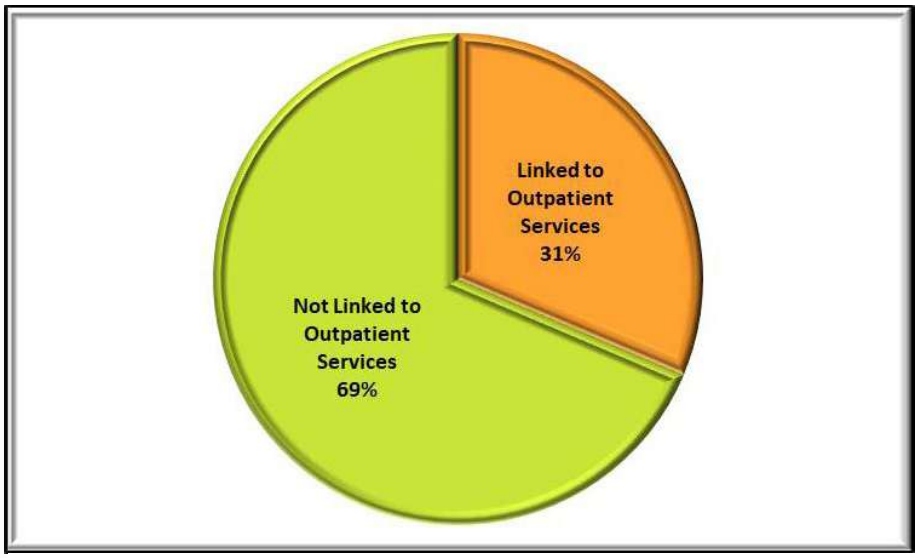


## *Community Assessment and Transport Team (CATT)*

Linkage to Outpatient Services

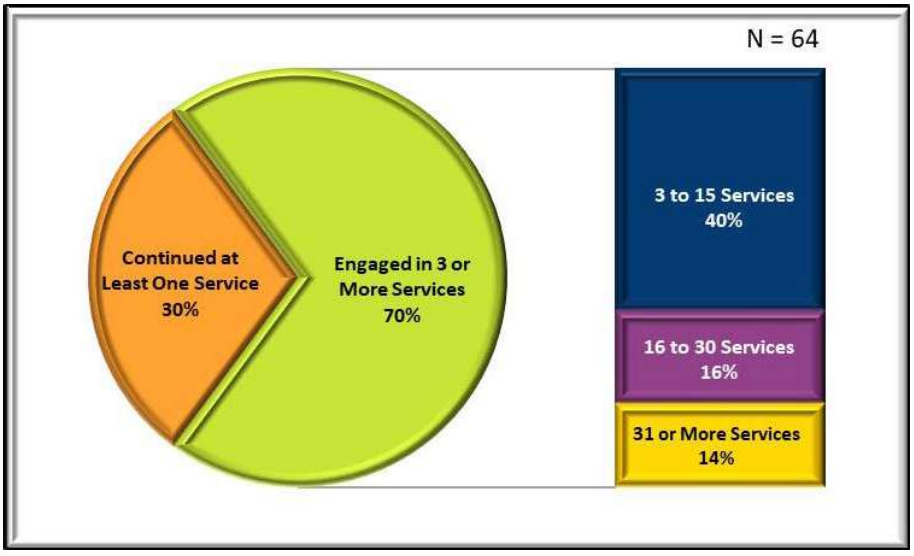
In addition to diverting individuals from an inpatient admission, the CATT team connects individuals to outpatient services. RUHS-BH service data was used to examine service usage after contact with the CATT team. Clients were considered to be linked to outpatient services if they had an outpatient, substance use, or youth short-term residential program service record. Individuals who were recorded as having private insurance were excluded from these analyses.

Outpatient Linkage for CATT clients




Almost a third (31%) of individuals served by the CATT team were linked to outpatient services after contact with teams. Some of the individuals who were linked to outpatient services (n = 29) were already participating in outpatient services prior to their contact with the CATT team.

Engagement in Services




The majority (70%) of CATT clients linked to outpatient services engaged in three or more services. For clients with 3 or more services, the average number of services was 22.

Recidivism Rates for CATT

| Days to Readmission | % |
|---|---|
| 0 to 15 Days | 16.51% |
| 16 to 30 Days | 0.92% |
| 0 to 30 Days | 17.43% |

Recidivism

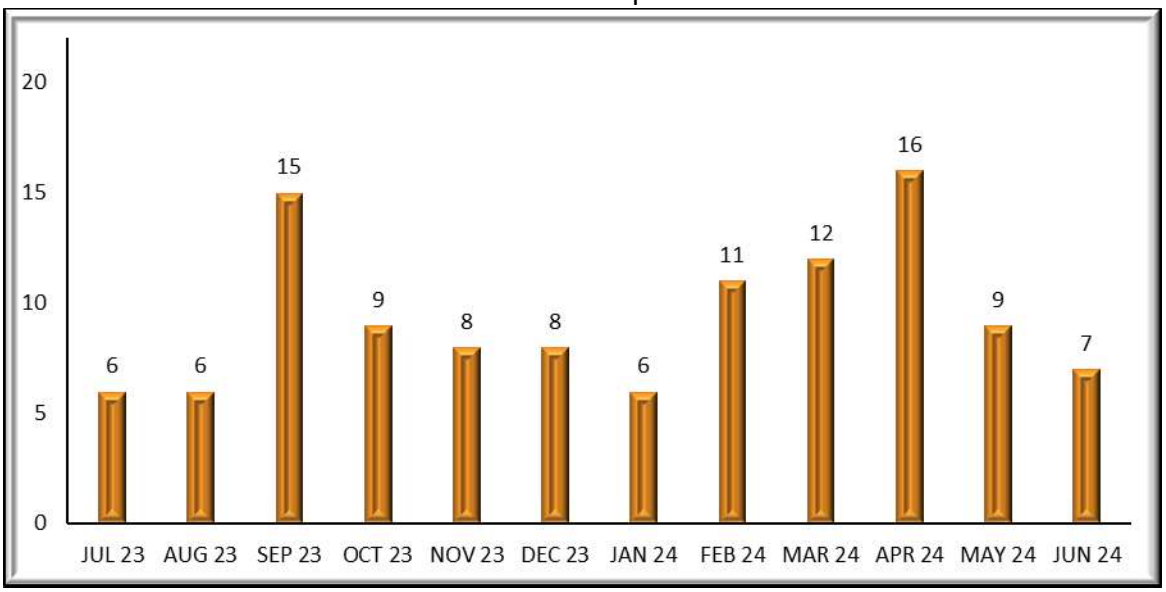
The table to the left provides the recidivism rates for the CATT team.

## *Behavioral Health Justice Intervention Services (BHJIS)*

Behavioral Health Justice Intervention Services (BHJIS) teams provide responsive crisis intervention support to students, reduce unnecessary hospitalizations and arrests, and connect students with on-going supports and services. Two RUHS-BH clinicians provide crisis services at four college campuses: College of the Desert, Riverside Community College, Riverside Community College-Moreno Valley Campus, University of California, Riverside (UCR). BHJIS began providing services in February of 2023. BHJIS had 113 Crisis contacts during the 2023-2024 Fiscal Year.

| BHJIS Crisis Contacts | |
|---|---|
| 113 | |
| College of the Desert | 70 |
| RCC - Mo Valley | 13 |
| RCC - Norco | 9 |
| RCC - Riverside | 12 |
| UC Riverside | 9 |

Number of Crisis requests for BHJIS



## *Behavioral Health Justice Intervention Services (BHJIS)*

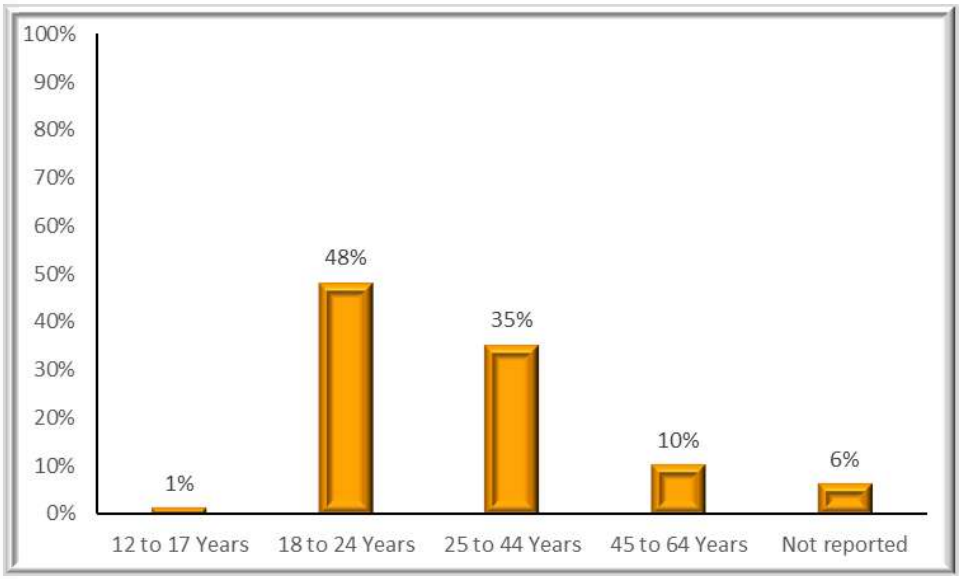
Demographics

BHJIS provided Crisis services to 102 individuals during the 2023-2024 fiscal year. BHJIS teams provided crisis services to more females (53%) than males (45%) Two percent of individuals served by BHJIS teams (n = 2) identified as transgender.

Gender of BHJIS Crisis clients

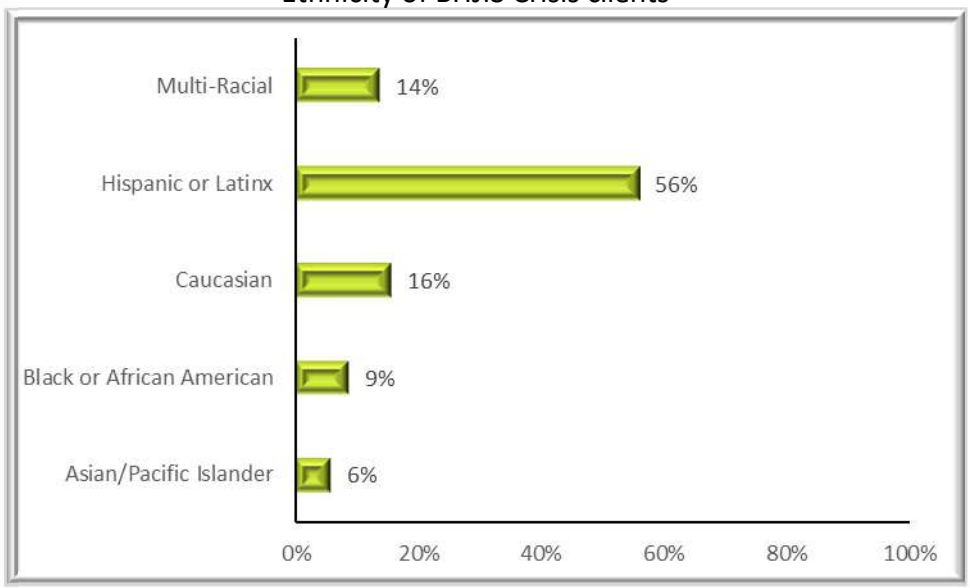
| Gender | N | % |
|---|---|---|
| Male | 46 | 45% |
| Female | 54 | 53% |
| Transgender | 2 | 2% |
| Total | 102 | 100% |

Age of BHJIS Crisis clients




Forty-eight percent (48%) of BHJIS crisis clients were age 18 to 44. Age was not reported for 6 clients.

Ethnicity of BHJIS Crisis clients



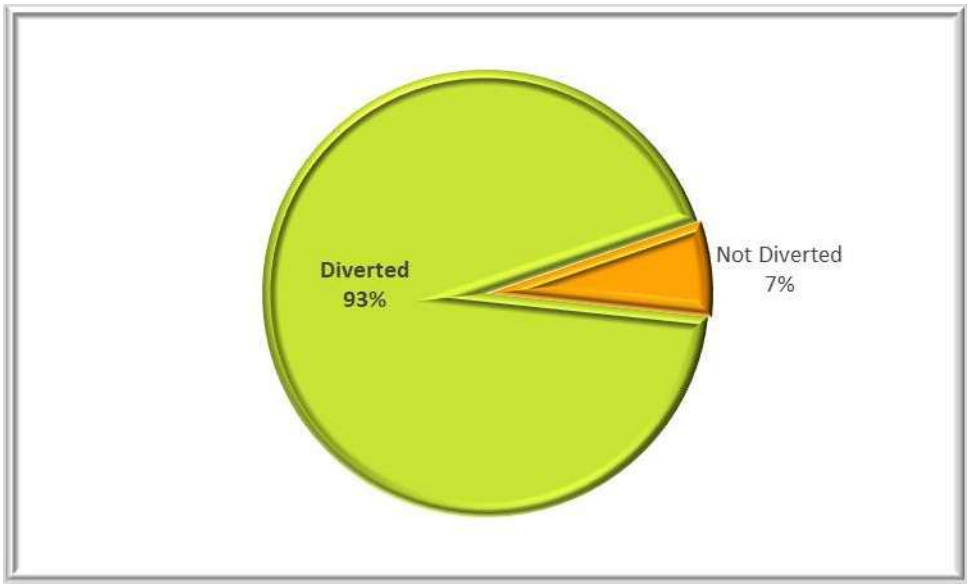

The majority of BHJIS crisis clients were Hispanics/Latinx (56%). Seventeen percent (17%) of BHJIS crisis clients reported experiencing homeless and 7% of clients were Veterans.

## *Behavioral Health Justice Intervention Services (BHJIS)*

Diversion from an Inpatient Admission

BHJIS teams divert individuals from an inpatient admission when possible. The figures below provide the percentage diverted as well as of the disposition of BHJIS crisis calls. Non-crisis contacts were excluded from these analyses. In addition, consumers who refused service (4%, n = 5) or who were arrested (2% n = 2) were also excluded from the analyses. Individuals were considered diverted if they returned home with a safety plan, went to the MHUC, or other community supports.

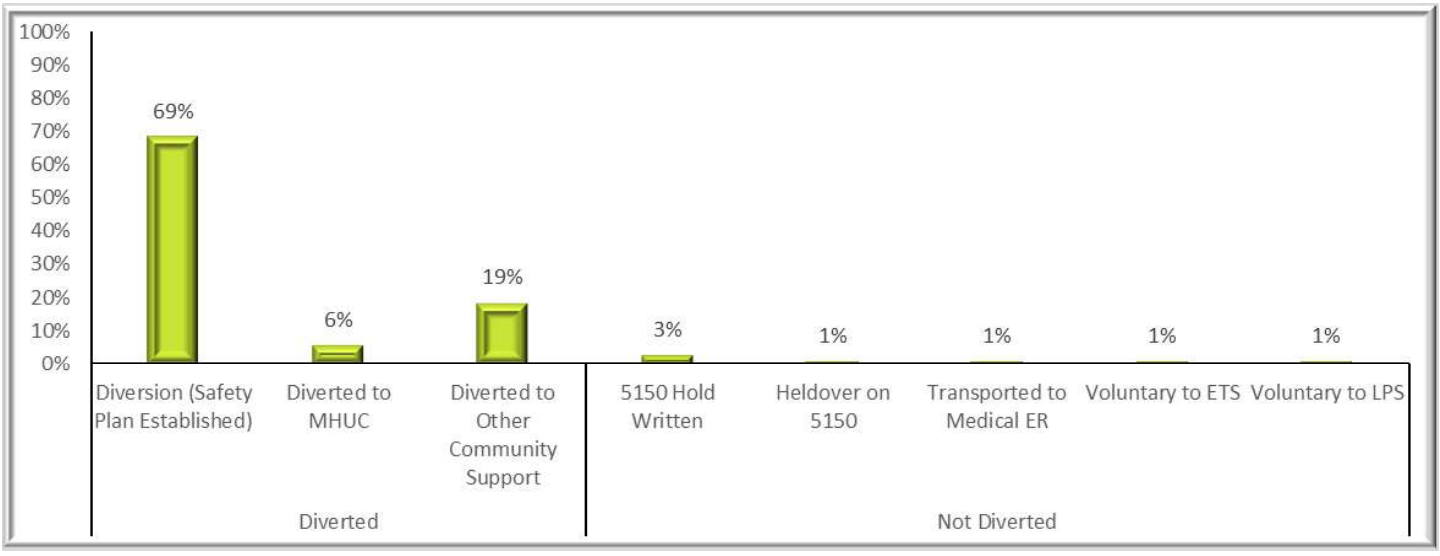
Percentage of Crisis Requests Diverted




BHJIS was able to divert 93% of crisis contacts.

The majority (93%) BHJIS crisis contacts were diverted to home, to an MHUC, or to other community supports.

Disposition of Crisis Requests



## *Behavioral Health Justice Intervention Services (BHJIS)*

Linkage to Outpatient Services

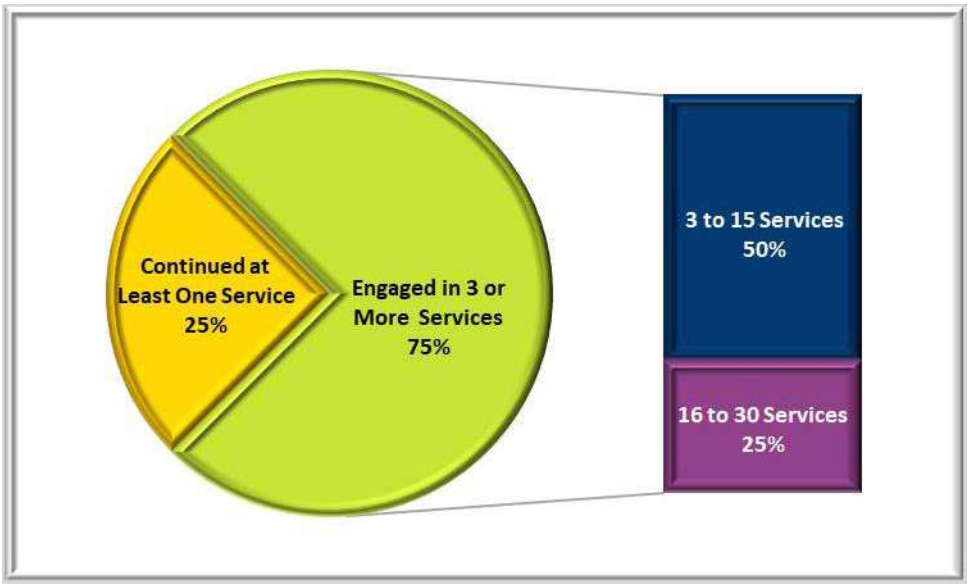
In addition to diverting individuals from an inpatient admission, BHJIS teams connect individuals with outpatient services. RUHS-BH service data was used to examine service usage after contact with BHJIS teams. Clients were considered to be linked to outpatient services if they had an outpatient, substance use, or youth short-term residential program service record. Individuals who were recorded as having private insurance were excluded from these analyses.

Outpatient Linkage for BHJIS clients

| Outpatient Services | N | % |
|---|---|---|
| Linked to Outpatient Services | 8 | 8% |
| Not Linked to Outpatient Services | 94 | 92% |

Eight percent (8%) of individuals served by BHJIS teams were linked to outpatient services after contact with teams. Some of those linked to outpatient services (n =3) were already participating in outpatient services prior to contact with teams.

Engagement in Services




The majority (75%) of those linked to outpatient services engaged in more than one service.

Readmission Rates for BHJIS

| Days to Readmission | % |
|---|---|
| 0 to 15 Days | 6.00% |
| 16 to 30 Days | - |
| 0 to 30 Days | 6.00% |

Recidivism

The table to the left provides the recidivism rates for BHJIS teams.

## *Mental Health Urgent Care (MHUC)*

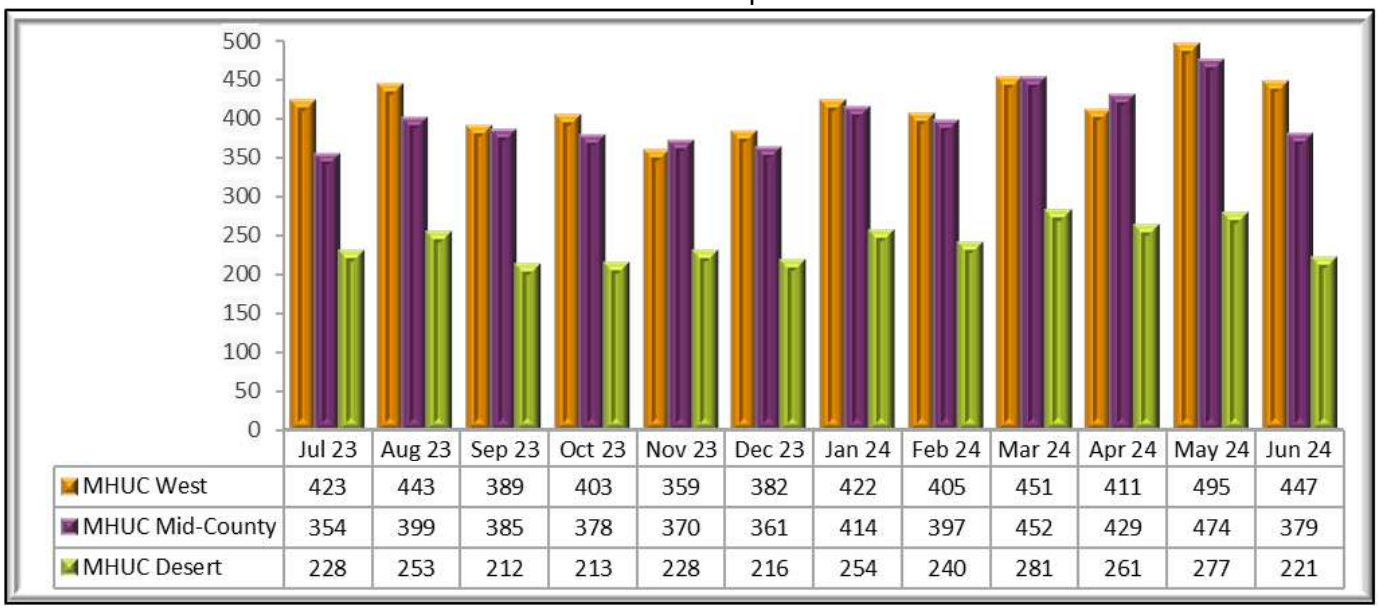
The Crisis Support System of Care includes three regional Mental Health Urgent Care (MHUC) facilities (Riverside, Perris, and Palm Springs). Individuals experiencing a mental health crisis can walk-in to an MHUC and receive individualized support 24 hours a day, 7 days a week. Staffed by a competent, caring team, MHUCs provide a safe, supportive, recovery-oriented environment. The MHUC offers a variety of services such as assessment, peer support, psychiatric and medication support, recovery education, community coordination and follow-up. The MHUCs serve individuals 18 years and older, while the Desert and Mid-County MHUCs serve adolescents 13 years and older.

Admissions

During the 2023/2024 fiscal year, MHUCs had a total of 12,706 admissions (July 1, 2023-June 30, 2024) and served 6,630 unduplicated clients. The figure below provides the MHUC admission per month for each MHUC.

| MHUC Admissions 12,706 | |
|---|---|
| MHUC West | 5,030 |
| MHUC Mid-County | 4,792 |
| MHUC Desert | 2,884 |

MHUC Admissions per Month




| | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 | Apr 24 | May 24 | Jun 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MHUC West | 423 | 443 | 389 | 403 | 359 | 382 | 422 | 405 | 451 | 411 | 495 | 447 |
| MHUC Mid-County | 354 | 399 | 385 | 378 | 370 | 361 | 414 | 397 | 452 | 429 | 474 | 379 |
| MHUC Desert | 228 | 253 | 212 | 213 | 228 | 216 | 254 | 240 | 281 | 261 | 277 | 221 |

## *Mental Health Urgent Care (MHUC)*

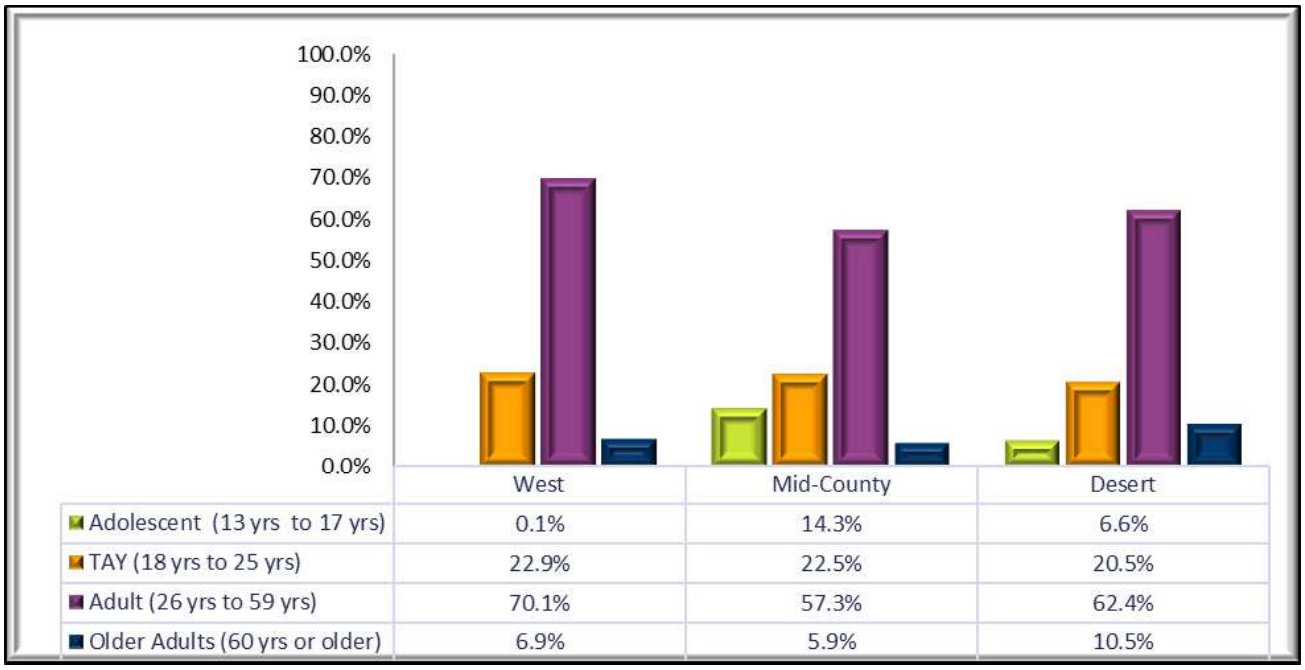
Demographics

MHUC facilities served 6,630 individuals during the 2023/2024 fiscal year. All three MHUCs served more male than female clients. Gender was not reported for 3 individuals.

| | Gender | | |
|---|---|---|---|
| | Male | Female | Not reported |
| MHUC | N (%) | N (%) | N (%) |
| West | 1488 (64.1%) | 833 (35.9%) | - |
| Mid-County | 1366 (51.1%) | 1305 (48.8%) | 3 (0.1%) |
| Desert | 905 (55.4%) | 730 (44.6%) | - |

The Mid-County and Desert MHUCs serve clients 13 years and older, while the West MHUC serves clients 18 years and older. Age was not reported for 2 clients.

Age of MHUC Clients




| Ethnicity | West | Mid-County | Desert |
|---|---|---|---|
| Am. Indian/Alaska Native | 0.6% | 0.4% | 1.0% |
| Asian/Pacific Is. | 2.7% | 16.5% | 1.5% |
| Black/African Am. | 13.0% | 13.1% | 9.0% |
| Hispanic/Latinx | 22.8% | 15.0% | 43.4% |
| Not reported | 36.2% | 29.1% | 3.2% |
| White/Caucasian | 24.8% | 25.8% | 41.9% |

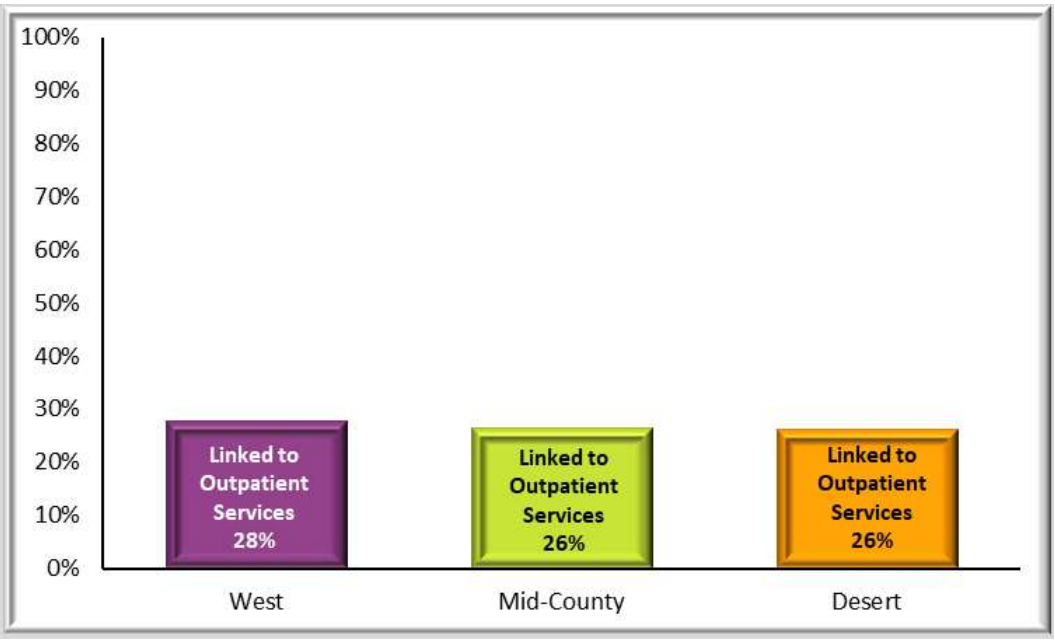
The MHUC Desert had the highest percentage of Hispanic/Latinx clients (43.4%).

## *Mental Health Urgent Care (MHUC)*

Linkage to Outpatient Services

The MHUCs assist consumers at discharge with linkage to outpatient services. Overall, 27% of those served by MHUCs, were linked to outpatient mental health/substance use services. The figure below provides the percent of individuals linked to outpatient mental health/substance use services after an admission at one of the county's MHUCs. Some individuals (n = 22 or 1%) were placed in a County short term Crisis Residential program (CRT) following their MHUC admission.

Percentage of MHUC Clients Linked to Outpatient Services




Recidivism

Recidivism rates for each of the three MHUCs are shown in the table below. Percentages are discharges from the MHUC followed by another admission for the same client 15 days or less or 16 to 30 days after an MHUC admission. Recidivism rates for 15 days or less were highest for the Western MHUC (33%).

Recidivism Rates for MHUCs

| Days to Readmission | West | Mid-county | Desert |
|---|---|---|---|
| 0 to 15 Days | 33% | 21% | 20% |
| 16 to 30 Days | 8% | 6% | 7% |
| 0 to 30 Days | 41% | 27% | 27% |

## *Crisis Residential Treatment Facilities (CRT)*

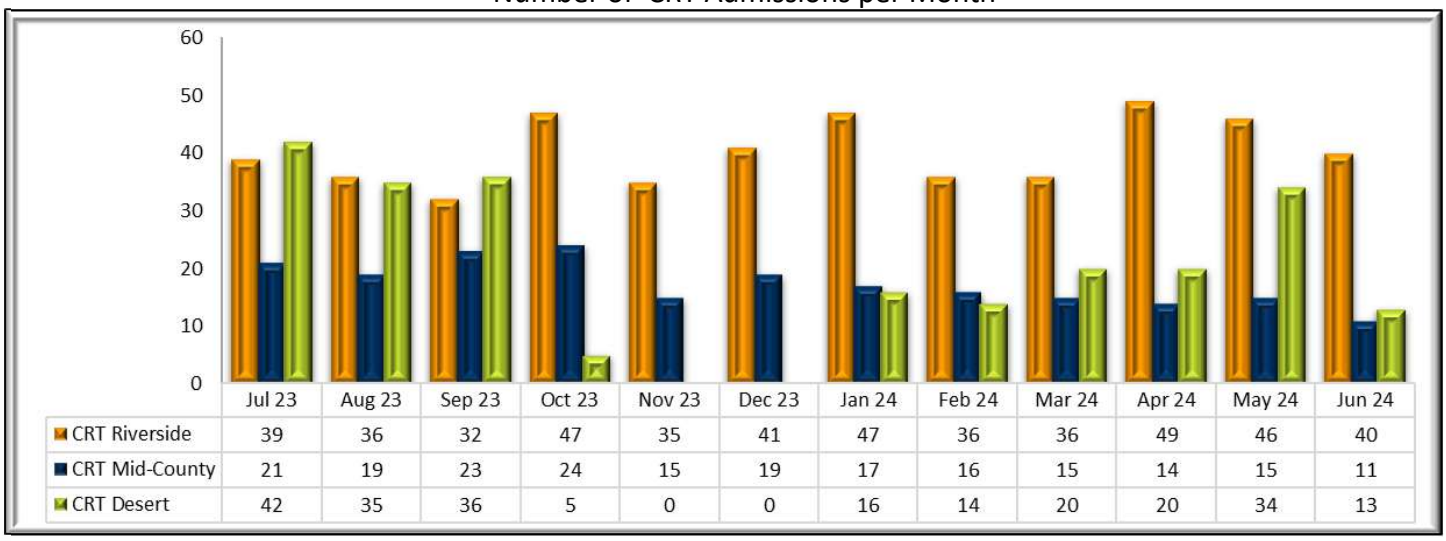
The voluntary Crisis Residential Treatment Facilities (CRT) provide enriched recovery based peer-to-peer support and interventions with the goal of stabilizing clients in acute crises, eliminating or reducing the need for inpatient hospitalization. Located in each of the three county regions, CRTs are designed to provide a home-like service environment. Each facility has a living room set up with smaller activity/conversation areas, private interview rooms, a family/group room, eight (8) bedrooms, laundry and cooking facilities, and a separate garden area. Individuals may stay at the facility for up to 14 days.

Admissions

The CRT facilities had 928 admissions during the 2023/2024 Fiscal Year. The figure below provides the number of CRT admissions per month for each CRT for the 2023/2024 fiscal year. The Mid-County CRT began serving clients in August 2021.

| CRT Admissions 928 | |
|---|---|
| West CRT (Lagos) | 484 |
| Mid-County CRT (Jackson House) | 209 |
| Desert CRT (Indio) | 235 |

Number of CRT Admissions per Month



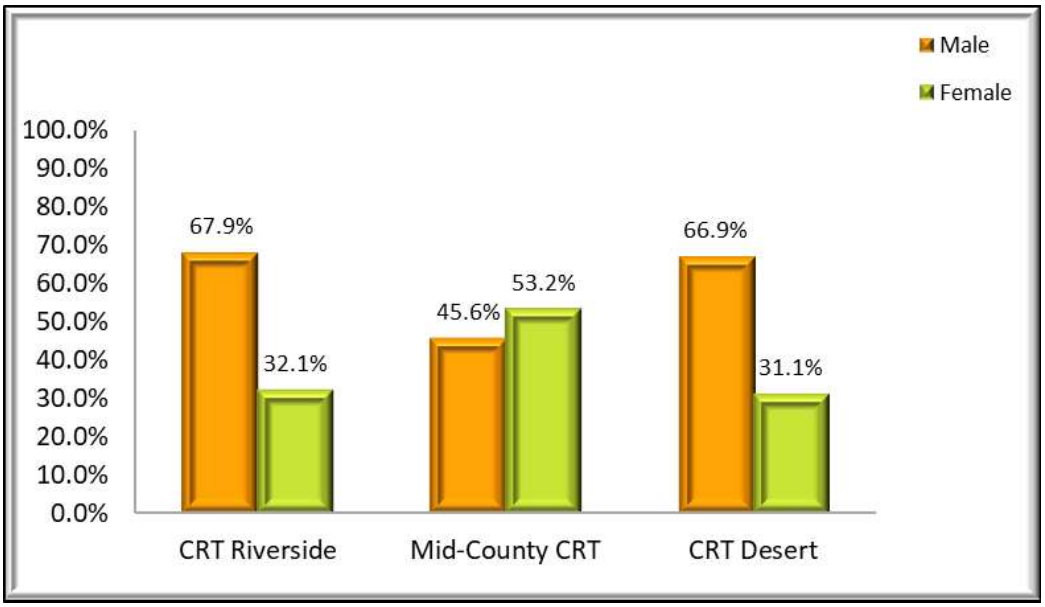

| | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 | Apr 24 | May 24 | Jun 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CRT Riverside | 39 | 36 | 32 | 47 | 35 | 41 | 47 | 36 | 36 | 49 | 46 | 40 |
| CRT Mid-County | 21 | 19 | 23 | 24 | 15 | 19 | 17 | 16 | 15 | 14 | 15 | 11 |
| CRT Desert | 42 | 35 | 36 | 5 | 0 | 0 | 16 | 14 | 20 | 20 | 34 | 13 |

## *Crisis Residential Treatment Facilities (CRT)*

Demographics

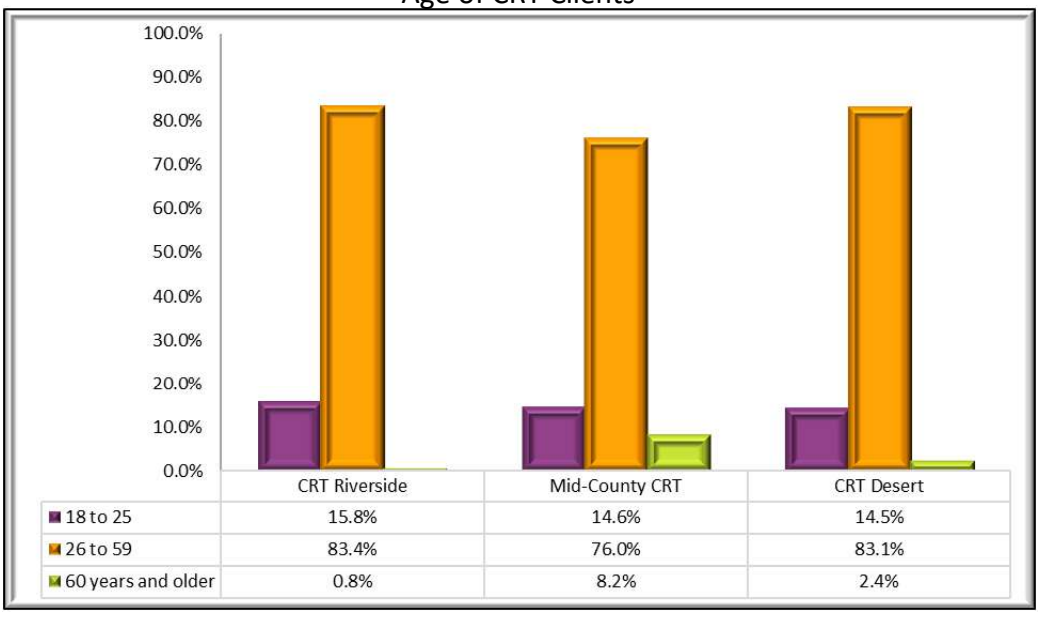
The CRT facilities served 815 individuals during the 2023/2024 fiscal year.

Gender of CRT Clients




More males than females were served by the Western and Desert CRTs. Gender was not reported for 2 individuals.

Age of CRT Clients




| | CRT Riverside | Mid-County CRT | CRT Desert |
|---|---|---|---|
| 18 to 25 | 15.8% | 14.6% | 14.5% |
| 26 to 59 | 83.4% | 76.0% | 83.1% |
| 60 years and older | 0.8% | 8.2% | 2.4% |

The majority of CRT clients were adults (age 26 to 59 years). Age was not reported for 11 individuals.

| Ethnicity | West CRT | Mid-County CRT | Desert CRT |
|---|---|---|---|
| Am. Indian/Alaska Native | 0.8% | 0.0% | 0.6% |
| Asian/Pacific Is. | 1.1% | 4.1% | 2.4% |
| Black/African Am. | 18.9% | 14.0% | 16.9% |
| Hispanic/Latinx | 35.8% | 27.5% | 42.8% |
| Multi-racial | 0.6% | 0.6% | 0.6% |
| Unknown | 13.0% | 6.4% | 7.2% |
| White/Caucasian | 29.9% | 47.4% | 30.1% |

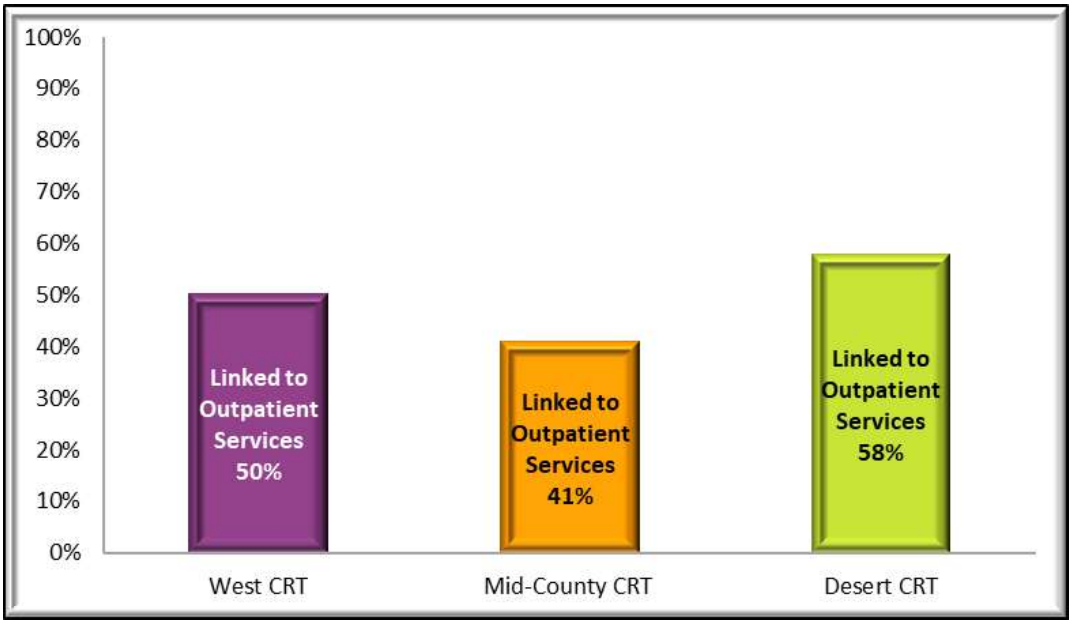
The Desert CRT served the highest percentage of Hispanic/Latinx clients (42.8%), while the Mid-County CRT served the highest percentage of White/Caucasian clients (47.4%).

## *Crisis Residential Treatment Facilities (CRT)*

Linkage to Outpatient Services

The CRTs assists clients at discharge with linkage to outpatient services. The percentage of clients linked to outpatient services after admission to a CRT was highest for the Desert CRT (58%).

Percentage of Clients Linked to Outpatient Services




Recidivism

Recidivism rates for the CRTs are shown in the table below. Percentages are discharges from the CRT followed by another admission for the same client within 15 days, 16 to 30 days, and 30 days or less. The Desert CRT had the highest rate of readmission for 15 days or less (8%).

Recidivism Rates for CRTs

| Days to Readmission | West | Mid-County | Desert |
|---|---|---|---|
| 0 to 15 Days | 7% | 4% | 8% |
| 16 to 30 Days | 6% | 3% | 4% |
| 0 to 30 Days | 12% | 7% | 12% |

## GSD: Mental Health Court and Justice Involved

### Incompetent To Stand Trial (IST):

For FY 23/24, Riverside County has 168 individuals who were found incompetent to stand trial and are awaiting transfer to a State Hospital for competency restoration with Felonies. These individuals spend an average of 3 months in Riverside County Jail waiting for an available State Hospital bed. The County's mission is to provide intensive community-based psychiatric treatment for these individuals. Rather than allowing them to remain in custody awaiting transfer to a State Hospital for competency restoration, they will be transferred to residential mental health treatment step-down programs where they will receive a wide array of behavioral health services. The ultimate purpose of this program is not restoration for adjudication but rather long-term psychiatric stabilization such that following completion of the Felony Incompetent to Stand Trial (FIST) program, one's legal charges can be dismissed, and he or she may reside in the community with on-going supportive behavioral health services.

During this review period, the IST Diversion program received 40 referrals, of which nine candidates were found to meet the requisite criteria and were accepted into the program. A frequent challenge encountered by behavioral health staff during the assessment and review process is finding out that the client has no interest in receiving mental health/medication services. Knowledge of this is a determining factor for the Court and often leads to a swift rejection of the program so that the Department of State Hospitals is aware that the person will not be diverted and to move forward with placement at one of their facilities.

### Laura Law's

**The Assisted Outpatient Treatment (AOT) Program, also known as Laura's Law**, is a community-based referral initiative for immediate family members, treatment agencies, licensed mental health professionals, peace officers, and judicial officers who believe that someone they know could benefit from court-ordered mental health or substance use services. In this process, a clinical therapist, case manager, and peer support specialist team will engage the consumer and provide outpatient services tailored to their needs. Suppose the consumer continues to decline efforts to involve them in outpatient services. In that case, AOT staff may escalate the referral to the AOT Review Committee and AOT Psychologist for further assessment and decision-making. Suppose the AOT Committee and Psychologist determine that court-ordered services are needed to stabilize the consumer in the community. In that case, a petition will be filed by County Counsel in Civil Court. Should the Court approve the treatment plan submitted with the petition, it will order the consumer to adhere to and participate in the recommended plan for up to six months.

During this reporting period, the AOT program received 99 referrals, of which 13 consumers accessed outpatient services voluntarily, and one was linked through Civil Court proceedings.

## HOME (Homeless Outreach, Mediation, and Education) Court –

is an alternative sentencing program developed for those facing criminal prosecution and suffering from homelessness. The program promotes community-based treatment to assist those individuals struggling with homelessness, who are in imminent danger of becoming homeless, and who are facing prosecution for quality-of-life infractions, misdemeanors, and low-level felonies. The overall goal of this program is to reduce recidivism and protect public safety by collaboratively working together with our justice partners, to address and treat the underlying needs of the participants through engagement in FSP-level services, intensive case management, and ongoing support from all members of the program, to ensure that each participant has the resources and opportunity they need to succeed in the community. This will be accomplished by recognizing each participant's accomplishments and efforts to resolve their cases and work towards reintegration as a successful and productive community member. While in the program, participants will focus on gaining residential stability, employment and/or education, substance and mental health rehabilitation, learning life skills, counseling, and family reunification. Throughout FY 23/24, the HOME Court program received 102 referrals from the court.

Overall Program Challenges: Obtaining housing for our consumers participating in the various Mental Health Court programs continues to be a challenge. We are often presented with individuals who are coming directly out of our community jails, who have no income or credit, and/or criminal charges, which causes landlords in an already tight housing market to not rent to them. There is also a constrained supply of beds for individuals for whom we seek institutional housing (such as adult residential facilities).

## *CARE (Community Assistance, Recovery, and Empowerment) Act*

The CARE Act will ensure mental health and other support services are provided to the most severely impaired Californians who too often languish without the treatment they desperately need. CARE will divert and prevent more restrictive conservatorships or incarceration to connect a person in crisis with a court-ordered CARE plan or agreement for up to 12 months, possibly extending for an additional 12 months. Individuals engaged in CARE plans and agreements may be prioritized for various services and programs, including supportive housing. The design of the CARE Act provides support and accountability for individuals with severe, untreated mental illnesses, as well as for local governments responsible for providing behavioral health services. The CARE process functions as a structure for counties to intensively engage individuals who may need additional support to access services consistently over a sustained period.

Specifically, the CARE Act allows certain people, called "petitioners," to request court-ordered treatment, services, support, and a housing plan for certain people 18 years of age or older, called "respondents," who have untreated severe mental illnesses, specifically schizophrenia or another psychotic disorder, and who meet certain health and safety criteria. Petitioners are encouraged to consider alternatives to CARE Act proceedings before filing a petition.

The CARE Act started in Riverside County on October 1, 2023. Over the course of FY 23/24, the CARE Act received 118 Civil Court petitions and 215 Integrated Referrals to assist in linking to it.

## Collaborative Courts

**Mental Health Court Program**:
Riverside County's first Mental Health Court program came into existence in November 2006 under Proposition 63, MHSA funding, and is in the Downtown Riverside area. The Mental Health Court program expanded its service area to include the Desert Region in 2007 and the Mid-County Region in 2009. The Mental Health Court program is a collaborative effort between Riverside University Health System Behavioral Health (RUHS – BH) and our partners in the Riverside Superior Court, Riverside County Public Defender and District Attorneys' offices, local private attorneys, Probation Department, Family Advocate, RUHS-BH community services, as well as private insurance services. Together with our partners, we work to develop a comprehensive 12-month program for each participant (must be at least 18 years of age) consisting of a stable place for the person to live, linkage to outpatient/community services to address their mental health/substance use treatment needs, as well as frequent oversight by the Probation Department and the Court. During FY 23/24, there were a total of 149 referrals received across all three regions, of which 40 were accepted into the program and a total of 76 successfully "promoted" from the program. Certain criteria must be met for the court to consider a participant ready to "promote" from the Mental Health Court program. The criteria require that a participant have a stable place to live, be actively engaged in their outpatient treatment for at least 90 consecutive days, have not produced a positive urinalysis over the last 90 days, and have never been charged with a new crime during their time in the program.

Additional programs under the Mental Health Court include Mental Health Diversion, Veterans Treatment Court, and Military Diversion.

**Mental Health Diversion Program:**
On July 1, 2018, Penal Code 1001.36, also known as Mental Health Diversion, came into effect as Governor Brown signed the budget. With the passage of this new pretrial diversion law, individuals who are accused of committing a crime may now be eligible to postpone any further action from taking place in their case(s), instead of receiving mental health treatment. During FY 23/24, the Mental Health Court received 641 referrals across all regions from the Riverside County Superior Court to assess individuals and assist the court in determining whether the person met the necessary criteria to be considered eligible for Mental Health Diversion.

As part of the assessment process, Mental Health Court staff will provide the court with a detailed treatment plan, which outlines recommended services for the individual and available housing options. Of the 641 referrals received, the court granted Mental Health Diversion in 226 cases. Because the Mental Health Diversion program may last anywhere from 12 – 24 months, the treatment plan prepared by Mental Health Court staff must also consider this

time when being developed. Should the court find the person eligible for the program and adopt the recommended treatment plan, Mental Health Court staff then work towards implementing the said treatment plan and provide follow-up case management services while the person is in the program. While in the program, participants are expected to be actively engaged in their treatment, remain abstinent from all illicit substances and alcohol, as well as report to the court at least every 30 – 90 days for a progress hearing. During this reporting period, 41 participants completed the Mental Health Diversion program, allowing them to have their charges dismissed and their arrest records sealed.

**Veterans Treatment Court/Military Diversion**

Veterans Treatment Court continues to positively impact the lives of the men and women who so valiantly served our country, along with those closest to them and the communities in which they live. From July 1, 2023, through June 30, 2024, the Veterans Treatment Court program received 59 new referrals. In addition, 166 referrals were received to assess Active Duty, Reserve, and Veterans interested in the Military Diversion program, which is also offered through the Veterans Treatment Court. Unlike Veterans Treatment Court, Military Diversion allows participants to enter the program without having to plead guilty, which is a unique benefit as it will enable those on Active Duty and in the Reserves to remain serving while they are also receiving treatment. During FY23/24, 82 participants graduated from Veterans Treatment Court or Military Diversion.

**Incompetent to Stand Trial (IST) Diversion program**

**Screening and Assessment**

The Incompetent to Stand Trial (IST) Diversion program provides services to justice-involved individuals who are at least eighteen (18) years of age, are being charged with felonies, and have been found incompetent to stand trial by the court. The process begins when a client's defense counsel formally declares a doubt on the record regarding the client's legal competence. The court then appoints at least one doctor (psychologist) to assess the client and determine whether the client is incompetent to stand trial. Should the appointed doctor(s) confirm that the client cannot stand trial, the court will refer the client to the Incompetent to Stand Trial (IST) program for a treatment and placement options recommendation.

Upon referral from the Presiding Judge, the IST clinician will assess the criminal justice-involved individual, either in custody or out, determine the appropriate level of mental health treatment, utilize the HC-20 risk assessment tool, and complete an initial treatment plan to be approved by the Judge. This treatment plan may include a referral to the Mental Health Rehabilitation Center (MHRC) or outpatient mental health services.

Upon the judge's approval of the initial treatment plan, the IST clinician may either refer the individual for outpatient mental health services and follow-up case management services

through the IST program's case manager or place the individual on the waiting list for a bed at the Mental Health Rehabilitation Center.

**Sentencing**

Because the court has found the person to be "incompetent to stand trial", all court proceedings are suspended until further notice, so the court is unable to sentence the person to participate in the recommended treatment plan; however, the court can order the person to engage in the recommended treatment plan as part of a pre-trial diversionary program, where the person has the opportunity to receive outpatient treatment instead of remaining in custody. If the treatment plan recommends placement at the MHRC, the court will order the person to be released from jail so that RUHS-BH staff may transport the person to the program.

**Follow-up and Placement:**

Placement for IST Participants is based on an appropriate level of mental health treatment as recommended to the court by the IST clinician. If outpatient services are recommended, the IST case manager will refer the participant to their local clinic to receive mental health/substance use treatment. The participant will also be ordered to return to court at the Judge's discretion, often every 30-60 days. At that time, the IST clinician or case manager will provide the court with a formal written update outlining the client's progress with their treatment plan.

**Areas Served:**

The IST Diversion program serves Riverside County and is located in the Forensics Administration offices in Downtown Riverside.

**Age Range Served:**

The Mental Health Court program services criminal justice-involved individuals ages 18 and beyond.

**Field-based services include:**

- Assessment to determine whether the client should receive services outpatient or within the state hospital.
- Linkage to outpatient mental health/substance use services and resources
- Follow-up services such as case management and advocacy in the courtroom
- Transportation services to and from various appointments, including but not limited to place of residence, clinic appointments, probation appointments, Social Security/Medi-Cal appointments, and court.
- Housing verification
- Interdisciplinary treatment team meetings

**HOME Court program**

**Screening and Assessment**

Potential clients are screened by the District Attorney, Public Defender, and a Superior Court Judge for participation in the HOME Court.

Upon referral from the Superior Court Judge, the HOME Court (HC) clinician will assess the justice-involved individual, either in custody or out, determine the appropriate level of mental health/substance use treatment, and complete an initial plan for services to be approved by the Judge.

Upon the judge's approval of the initial treatment plan, the HC treatment team will collaborate with the community-based outpatient mental health/substance use programs and formalize the recommended strategy to be included in the terms and conditions of probation.

Sentencing

After a Superior Court Judge reviews the recommended treatment plan, the client is sentenced based on a consensus between the Judge, the District Attorney, the Public Defender, and the Candidate. To participate in HOME Court, clients must agree to the terms and conditions of the sentencing.

**Follow-up and Placement:**

Placement for HOME Court Participants is based on an appropriate level of mental health/substance use treatment as recommended by the HOME Court treatment team (clinicians and case manager). During the assessment phase, the HOME Court clinician will collaborate with the candidate, significant other, family, and/or friends about mental health/substance use treatment and placement options.

HOME Court collaborates with the Riverside Superior Court and our Colleagues in the District Attorney's and Public Defender's office, Probation Department, and Riverside County Sheriff's to address the assessment, sentencing, and placement of criminal defendants suffering from mental health/substance use issues to decrease jail recidivism, provide linkage for mental health/substance use treatment, either in outpatient mental health services, substance abuse services, vocational rehabilitation services or dual diagnosis treatment facilities. The program also strives to increase treatment compliance through additional case management services and support from the Riverside County Probation and Sheriff's Department.

**Areas Served:**

HOME Court program is broken up into four smaller programs designed to cover the whole of Riverside County as follows:

- Riverside HOME Court: Covers the Western region of Riverside County.
- Temecula HOME Court: Covers the Mid-County region of Riverside County.
- Indio HOME Court and Banning HOME Court: Cover the Desert region of Riverside County.

**Age Range Served:**

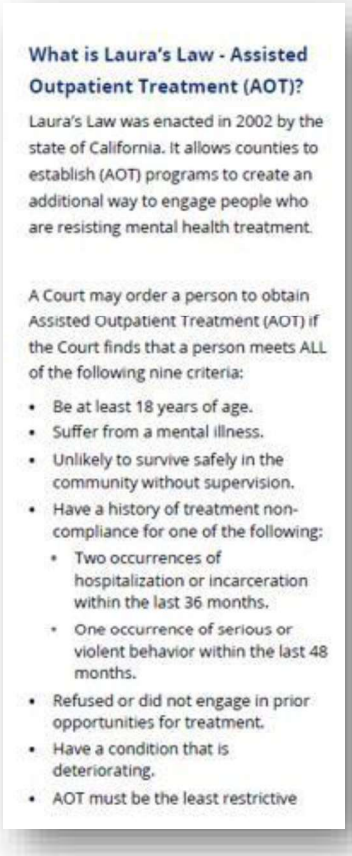
HOME Court program provides services to individuals involved in criminal justice ages 18 and beyond.

**Field-based services include:**

- Assessment to determine program eligibility
- Linkage to outpatient mental health/substance use services and resources
- Follow-up services such as case management and advocacy in the courtroom
- Transportation services to and from various appointments, including but not limited to place of residence, clinic appointments, probation appointments, Social Security/Medi-Cal appointments, and court.
- Housing verification
- Interdisciplinary treatment team meetings

**Laura's Law The Assisted Outpatient Treatment (AOT) program**

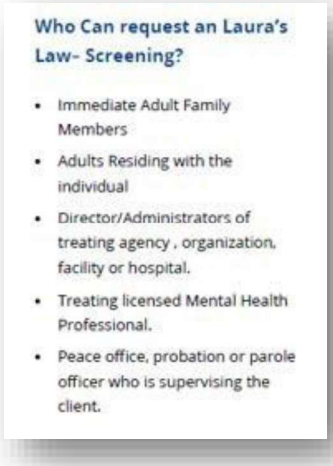
Laura's Law, also known as Assisted Outpatient Treatment (AOT), is intensive court-ordered community-based treatment for individuals struggling with voluntarily addressing behavioral health symptoms. AOT is only used when an individual has demonstrated difficulty or challenges in voluntarily engaging in behavioral health treatment. AOT serves as a bridge to recovery for those released from inpatient facilities and as an alternative to hospitalization. Assisted outpatient treatment's primary objectives are to re-engage the consumer in behavioral treatment while also helping with the reduction of re-hospitalizations, re-incarceration, and homelessness.




Riverside University Health System—Behavioral Health (RUHS-BH) staff perform assisted outpatient treatment; referral and linkage are performed to the nearby county-operated outpatient clinic or full-service partnership (FSP).

**Laura's Law Program Design/Model**

The Laura's Law program is comprised of the following services and curriculum:




Mental Health Services

- Behavioral health screening
- Mental health assessment
- Therapy (couple, individual, family)
- Group therapy (PTSD, Anger Management, DBT)
- Case management
- Psychiatric evaluation and medication services

Substance Use Disorder Services

- American Society of Addiction Medicine (ASAM) assessment
- Substance Abuse Intake Assessment
- Therapy (couple, individual, family)
- Psychiatric evaluation and medication services

• Linkage to residential treatment as needed

| Program Curriculum | Evidence-Based Rating | Brief Program Description |
|---|---|---|
| Anger Management | EBP – Well Supported | Class that helps individuals identify triggers for anger and deal with emotions that may lead to reoffending or relapse. The curriculum includes coping skills to address specific behaviors. |
| CORE | Emerging Practice | The program combines the ideas of change and recovery to assist the client through the re-entry process. Groups focus on both mental health struggles and substance use issues. |
| Courage to Change (C2C) | Promising Practice | An interactive journaling system designed to address the "Big Six" criminogenic needs of individuals who are working to successfully reintegrate into their communities. |
| Criminal and Addictive Thinking (CAT) | Promising Practice | A cognitive-behavioral treatment that focuses on distorted core beliefs to change criminal and addictive thinking patterns which lead to re-offending. This program comes with a corresponding workbook that is completed during the course. |
| Dialectical Behavioral Therapy (DBT) | EBP – Well Supported | A comprehensive treatment used to address complex mental health problems and regulate emotions. |
| Educate, Equip, & Support (EES) | EBP – Well Supported | Program offered to parents/caregivers raising a child/youth with mental health and/or emotional challenges. Classes provide parents/caregivers with general education about children's mental health challenges, available supports, and community resources. |
| Facing Up | Emerging Practice | Class that provides simple suggestions for developing a healthy family environment. Allows caregivers opportunities to share challenges in a supportive environment and discusses how to develop a family wellness plan. |
| Nurturing Parenting | EBP – Well Supported | An interactive course that helps individuals better understand their role as a parent. Program aims to enhance self-care, empathy, and self-awareness among participants. |
| Seeking Safety | EBP – Well Supported | Counseling model that addresses trauma and/or post-traumatic stress disorder (PTSD) and addiction exploring the relationship between the two. The curriculum teaches safe |

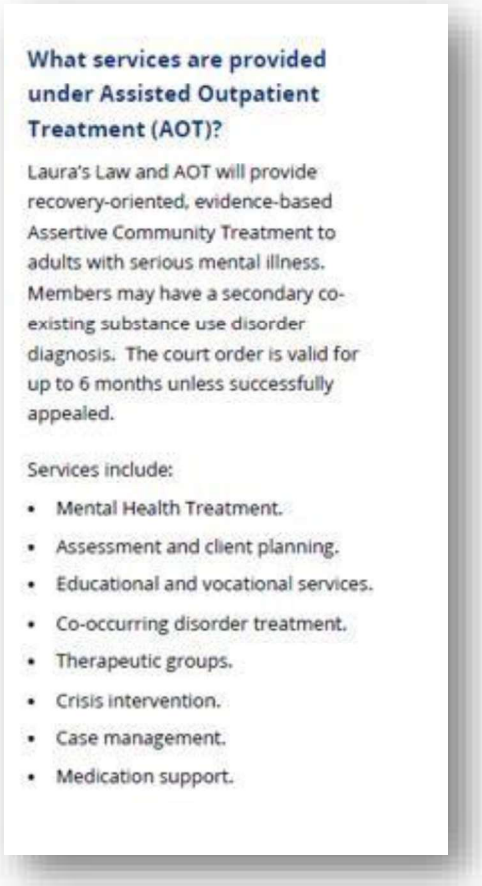
Anticipated changes to Laura's Law Program: RUHS-BH anticipates program growth as the community learns more about the program through our media and marketing outreach, including department social media platforms such as Facebook and Instagram. There have been (12) individuals referred to the Laura's Law program in Riverside County. Over time, we expect the number of individuals referred and treated with the assisted outpatient treatment program to be around 100. Hence, we anticipate additional staffing positions will be required

to ensure caseloads of 10:1 to meet the time and commitment demands to assist individuals in AOT.

Lessons Learned: The positive outcomes or lessons learned thus far is the importance of a strong collaboration with the courts, county counsel, and public defender's office, as well as internal and external partners. In addition, the importance of patient rights advocates in educating the consumers about the Laura's Law program and their rights and offering advocacy to navigate the AOT process. Some challenges are vetting the referrals to explore if a least restrictive approach is available to address the concerns as required by law. The challenge relating to this factor is, at times, the person making the referral (e.g., family or community member) does not understand that Laura's Law has strict guidelines on how to be referred to the court for AOT to ensure voluntary or least restrictive services are considered first.

Progress Data: Laura's Law program outcomes are focused on evaluating changes in a consumer's status relative to several quality-of-life domains. Baseline histories are obtained from consumers at enrollment into the FSP program. Follow-up data is collected continuously for key life events (e.g., hospitalizations) and is assessed periodically for other select life domains. Outcome reporting is based on baseline and post-enrollment status comparisons and measures program effectiveness.

Laura's Law consumers are provided services at New Life FFSP. Below are outcome measures performance for FY 21/22:

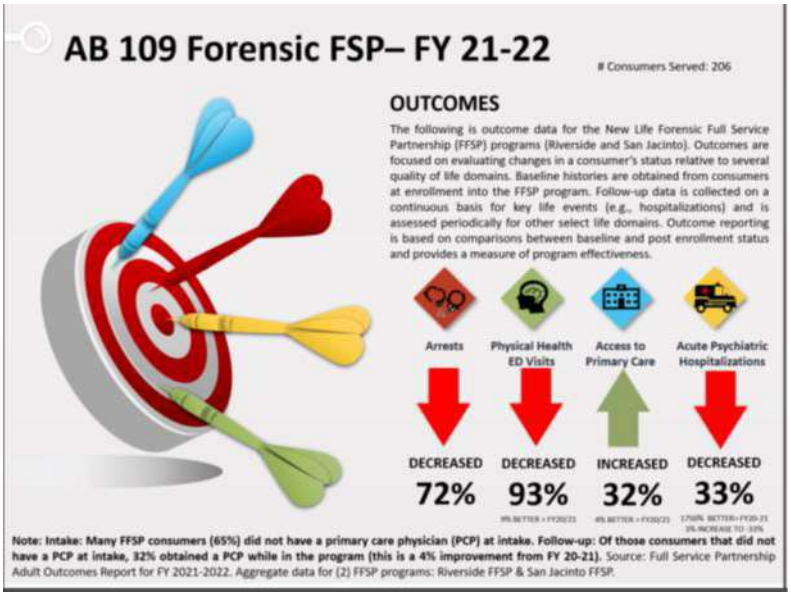


**What services are provided under Assisted Outpatient Treatment (AOT)?**

Laura's Law and AOT will provide recovery-oriented, evidence-based Assertive Community Treatment to adults with serious mental illness. Members may have a secondary co-existing substance use disorder diagnosis. The court order is valid for up to 6 months unless successfully appealed.

Services include:

- Mental Health Treatment.
- Assessment and client planning.
- Educational and vocational services.
- Co-occurring disorder treatment.
- Therapeutic groups.
- Crisis intervention.
- Case management.
- Medication support.




Outcomes indicate that Laura's Law consumers had a 72% reduction in arrests, a 93% decrease in emergency department visits, a 33% decrease in acute psychiatric inpatient hospitalizations, and a 32% increase in access to primary care.

**Referral Information**

- To initiate the process of Laura Law referral please call the 24 hours CARES Line number:
  1-800-499-3008
- If appropriate, the LLAOT Screening and Referral Team will conduct the outreach, screening and linkage to services.

In the 2021/2022 fiscal year, more than half of the Laura' Law consumers received 4-7 or 8 or more services a month. The highest average hours of services during the 2020/2021 fiscal year were for mental health group services (27.96 hours), individual mental health services (4.18 hours), and case management (4.26 hours).

**3-Year Plans & Goals:** The Laura's Law program focuses on (6) primary goals and/or outcome measures:

• Consumer adherence to behavioral treatment in AOT with eventual step-down to voluntary outpatient behavioral health services based on retention and attrition rates
• Increase the number of served to 100 individuals within the 3-year plan
• Reduce hospitalizations
• Reduce arrests
• Reduce physical health emergency admissions
• Reduce mental health emergency department visits
• Increase access to primary care physician

**Annual Update: Progress Report on 3-Year Plan**

3-Year Plans & Goals: The Laura's Law program focuses on (6) primary goals and/or outcome measures:

• **Goal:** Consumer adherence to behavioral treatment in AOT with eventual step-down to voluntary outpatient behavioral health services based on retention and attrition rates.
Progress Update: In progress. We are continuing to evaluate Laura's Law cases and treatment with the goal of stepdown to voluntary outpatient services. There have been numerous

instances where engagement with our Laura's Law team has led to consumers agreeing to re-engage with outpatient treatment in lieu of their case being sent to courts to mandate treatment.

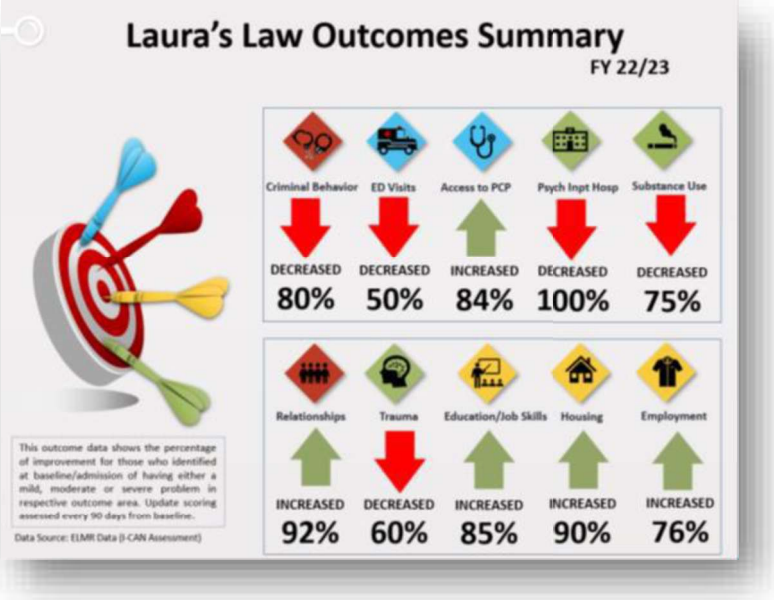
• **Goal:** Increase the number of served to 100 individuals within the 3-year plan. Progress Update: We are on target to surpass our goal of 100 individuals served in Laura's Law within the 3-year plan. We have received (24) referrals for Laura's law in the last two months.
• Goal: Reduce hospitalizations Progress Update: We have prevented psychiatric hospitalizations by 100% by connecting consumers to the least restrictive crisis options, such as linkage to Crisis Stabilization Units, Crisis Residential Treatment, Sobering Centers, and county clinics.

• **Goal:** Reduce arrests Progress Update: We have been able to reduce criminal behavior, including arrests, by 80% compared to consumers' baseline scores.

• **Goal:** Reduce physical health emergency admissions Progress Update: Consumer visits to emergency departments for non-physical health emergencies have decreased by 50%.

• **Goal**: Reduce mental health emergency department visits. Progress Update: This goal was modified and replaced with the following other outcome areas in the table below since the preceding goal above covered the emergency department outcome.
• **Goal**: Increase access to primary care physicians Progress Update: Consumer visits to emergency departments for non-physical health emergencies have improved by 84%.

Below is the Laura's Law Outcomes Summary showing consumer improvements in areas of focus:



**Screening and Assessment**
Potential referral sources include, but are not limited to, Riverside County Superior Court Criminal/Civil Judges, Attorneys, Law Enforcement, Acute Psychiatric Hospitals, and members of the community.

Upon receipt of a referral, the AOT clinician will attempt to meet with the referred individuals and assess them to determine the appropriate level of mental health/substance use treatment and whether other requisite criteria, such as an unwillingness to engage in outpatient services voluntarily, exist. Suppose the AOT clinician renders a clinical opinion that the client likely meets the necessary criteria for the program. In that case, the case will be forwarded for further review by the AOT Committee. Should the AOT Committee agree with the AOT clinician's findings, the case will be referred to the AOT Psychologist, who will provide a final evaluation of the client and write a formal declaration outlining their conclusions and supporting evidence. The formal declaration is then filed as a petition with the court, who will determine whether the referred individual requires the level of intervention provided by the AOT program.

**Sentencing**
After a Superior Court Judge reviews the petition and agrees with the findings outlined within, the client is ordered to participate in the treatment plan being recommended for them, which may include but is not limited to, outpatient mental health and/or substance use services.

**Follow-up and Placement:**
Placement for AOT Participants is based on an appropriate level of mental health/substance use treatment as recommended by the AOT treatment team (clinicians and case manager). During the pre-trial phase, the AOT clinician and psychologist will collaborate with the client, the client's significant other, family, and/or friends about mental health/substance use treatment and placement options.

AOT team collaborates with our outpatient partners/providers to assess those in our community who are suffering from mental health issues to decrease acute hospital utilization and jail recidivism by providing linkage for mental health treatment, either in outpatient mental health services, substance abuse services, vocational rehabilitation services or dual diagnosis treatment facilities. The program also strives to increase treatment compliance by implementing intensive case management services.

**Areas Served:**
The AOT program is broken up into two smaller programs designed to cover the whole of Riverside County as follows:

- Riverside AOT: Covers the Western and Mid-County region of Riverside County.
- Indio AOT: Covers the Desert region of Riverside County.

**Age Range Served:**
AOT program provides services to mentally ill individuals ages 18 and beyond.

**Field-based services include:**

- Assessment to determine program eligibility
- Linkage to outpatient mental health/substance use services and resources
- Follow-up services such as case management and advocacy in the courtroom
- Transportation services to and from various appointments, including but not limited to place of residence, clinic appointments, probation appointments, Social Security/Medi-Cal appointments, and court.
- Housing verification
- Interdisciplinary treatment team meetings

**CARE Court**

**Screening and Assessment**

Potential referral sources include, but are not limited to, Riverside County Superior Court Criminal/Civil Judges, Attorneys, Law Enforcement, Acute Psychiatric Hospitals, RUHS-BH staff, and members of the community.

Upon receipt of a referral, the CARE court clinician will reach out to the person who made the referral to gather more information and attempt to meet with the referred individuals and assess them to determine the appropriate level of mental health/substance use treatment, and whether other requisite criteria such as an unwillingness to engage in outpatient services voluntarily exist. Suppose the CARE clinician renders a clinical opinion that the client likely meets the necessary criteria for the program. In that case, the clinician will complete the CARE 100 and forward it to the Administrator, who will review it. If approved, the Deputy Director and Assistant Director will send the case for further review. Should the Deputy Director and Assistant Director agree with the findings, the case will be sent to our attorney, who will file the petition with the court.

Petitions are also filed with the court directly from petitioners without going through CARE court staff. Once filed, CARE court receives these petitions along with other documents that need to be completed by CARE court staff.

**Sentencing**

This is a civil court, and no sentencing is done. A Superior Court Judge oversees the petition and the care plan/agreement and holds RUHS-BH accountable for providing the treatment needed for the client.

**Follow-up and Placement:**

Placement for CARE Participants is based on an appropriate level of mental health/substance use treatment as recommended by the CARE treatment team and in agreement with the client and attorneys.

CARE court team collaborates with our outpatient partners/providers to assess those in our community who are suffering from mental health issues to decrease acute hospital utilization and jail recidivism by providing linkage for mental health treatment, either in outpatient mental health services, substance abuse services, vocational rehabilitation services or dual diagnosis treatment facilities. The program also strives to increase treatment compliance by implementing intensive case management services.

**Areas Served:**
The CARE court program is broken up into two smaller programs designed to cover the whole of Riverside County as follows:

- Riverside CARE court: Covers the Western and Mid-County region of Riverside County.
- Indio CARE court: Covers the Desert region of Riverside County.

**Age Range Served:**
CARE court provides services to mentally ill individuals ages 18 and beyond.

**Field-based services include:**

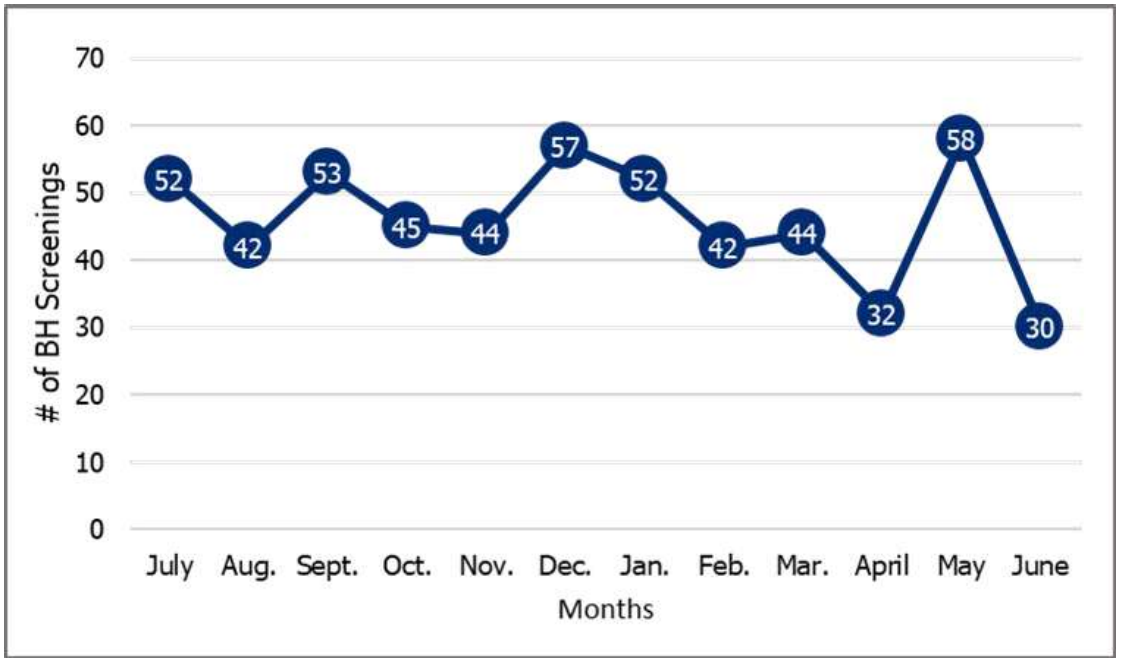
- Assessment to determine program eligibility
- Linkage to outpatient mental health/substance use services and resources
- Follow-up services such as case management and advocacy in the courtroom
- Transportation services to and from various appointments, including but not limited to place of residence, clinic appointments, probation appointments, Social Security/Medi-Cal appointments, and court.
- Housing verification
- Interdisciplinary treatment team meetings

## *GSD: Juvenile Justice*

### Behavioral Health Screening

Riverside University Health System-Behavioral Health (RUHS-BH) screens all youth for behavioral health needs at admission into Juvenile Hall. Screening data from Juvenile Justice is collected monthly from the beginning to the end of each calendar month. Between July 1, 2023, and June 30, 2024, 551 screenings were conducted. As shown in **Figure 1**, the number of screenings conducted each month ranged from a low of 30 completed in June to a high of 58 completed in May. Pre-release behavioral health evaluations were also performed for a few youths.

**Figure 1:** Number of Behavioral Health Screenings Conducted per Month




Behavioral health screenings identify youth with various developmental, behavioral health, and substance abuse issues. **Table 1** shows additional information on screened youth. Very few incoming youth were currently experiencing withdrawal and none were developmentally disabled.

**Table 1:** Additional Characteristics Screened Youth by Month

| | July. 2023 | Aug. 2023 | Sept. 2023 | Oct. 2023 | Nov. 2023 | Dec. 2023 | Jan. 2024 | Feb. 2024 | Mar. 2024 | April. 2024 | May. 2024 | June. 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Substance Abuse History** | 32 | 28 | 33 | 28 | 21 | 26 | 26 | 19 | 18 | 14 | 24 | 13 |
| **Current Withdrawal** | 1 | 1 | 1 | 3 | 1 | 1 | 0 | 1 | 0 | 1 | 1 | 0 |
| **Developmentally Disabled Youth** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

## Behavioral Health Assessments and Referrals

After screening, some youth are provided with additional assessment services. As shown in **Table 2** below, between 1 and 14 assessments were conducted by RUHS-BH staff monthly within FY 23/24; averaging 3 monthly assessments.

Furthermore, some youth may have already received a behavioral health assessment before their admission into juvenile hall because some youth entering juvenile hall are already receiving behavioral health services when admitted; that information is available to juvenile hall staff via the County Electronic Management of Records (ELMR) system.

**Table 2:** Number of Assessments Conducted per Month from RUHS-BH Electronic Data System

| | July. 2023 | Aug. 2023 | Sept. 2023 | Oct. 2023 | Nov. 2023 | Dec. 2023 | Jan. 2024 | Feb. 2024 | Mar. 2024 | April. 2024 | May. 2024 | June. 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Assessments** | 3 | 0 | 0 | 1 | 2 | 0 | 1 | 4 | 14 | 6 | 1 | 4 |

**Table 3** shows the number of behavioral health referrals, by referral type, that were received each month of FY 23/24 according to the monthly service report. Requests to serve youth come from within the Juvenile Hall itself as well as externally from the court.

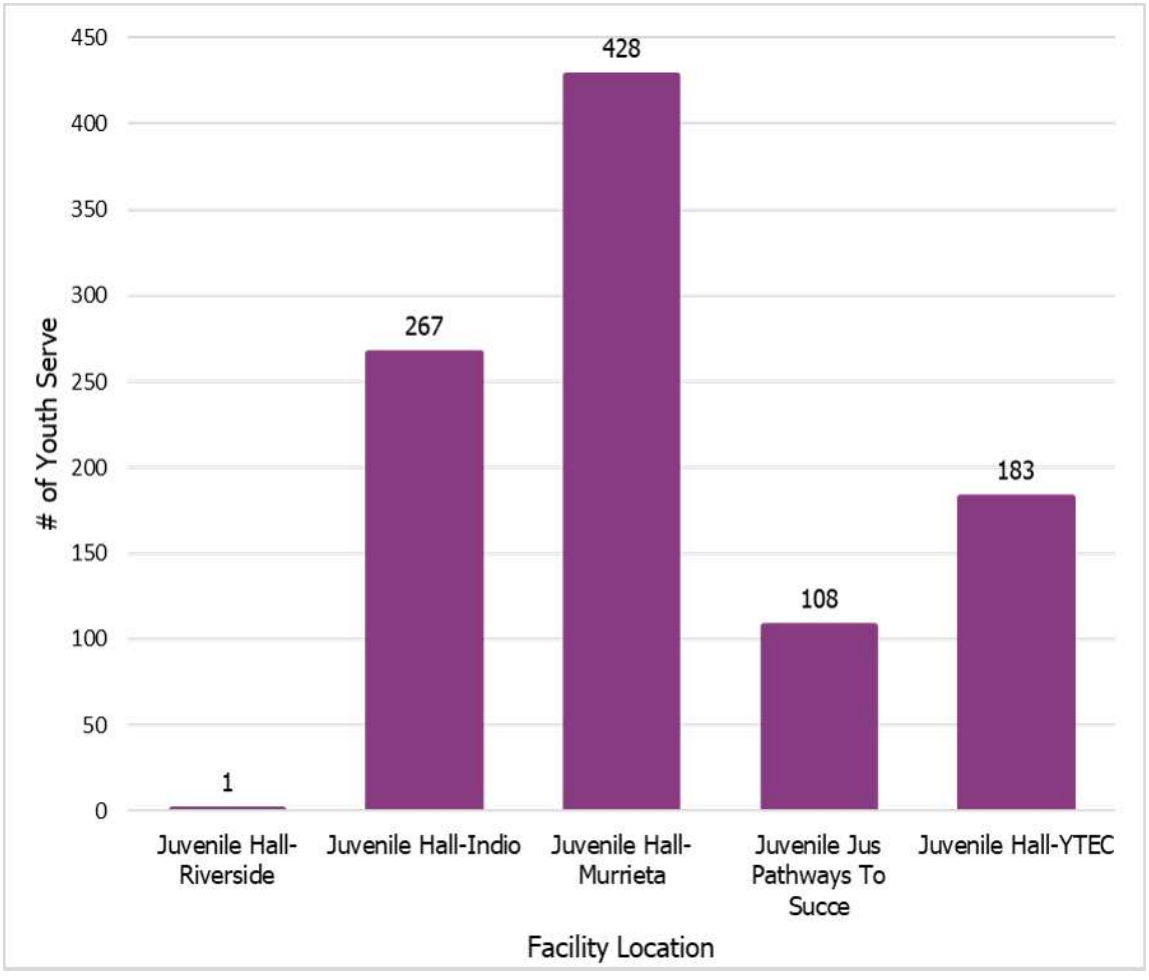
**Table 3:** Juvenile Hall Referrals per Month

| | July. 2023 | Aug. 2023 | Sept. 2023 | Oct. 2023 | Nov. 2023 | Dec. 2023 | Jan. 2024 | Feb. 2024 | Mar. 2024 | April. 2024 | May. 2024 | June. 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Court Referrals** | 1 | 1 | 1 | 1 | 0 | 4 | 1 | 1 | 5 | 9 | 17 | 4 |
| **Juvenile Hall Referrals** | 161 | 153 | 103 | 108 | 137 | 113 | 165 | 99 | 142 | 129 | 242 | 117 |

## Behavioral Health Service Data

Service data for all youth served in one of the four Riverside County Juvenile Justice facilities within FY 23/24 was obtained from the RUHS-BH electronic health records (ELMR) system. During FY 23/24, RUHS-BH Juvenile Justice provided behavioral health services to 987 youth. **Figure 2** below shows the number of youth served at each facility. Since, at times, youth are transferred from one facility location to another, youth may be served by more than one facility location over the fiscal year. Also, some youth in the Youth Treatment and Education Centers (YTEC) may start in Juvenile Hall, thus having services in both types of facilities. Due to some youth being served at more than one facility, the total in **Figure 2** below reflects the unique number served at each location and does not sum to the total unduplicated youth (n=647) served within the fiscal year.

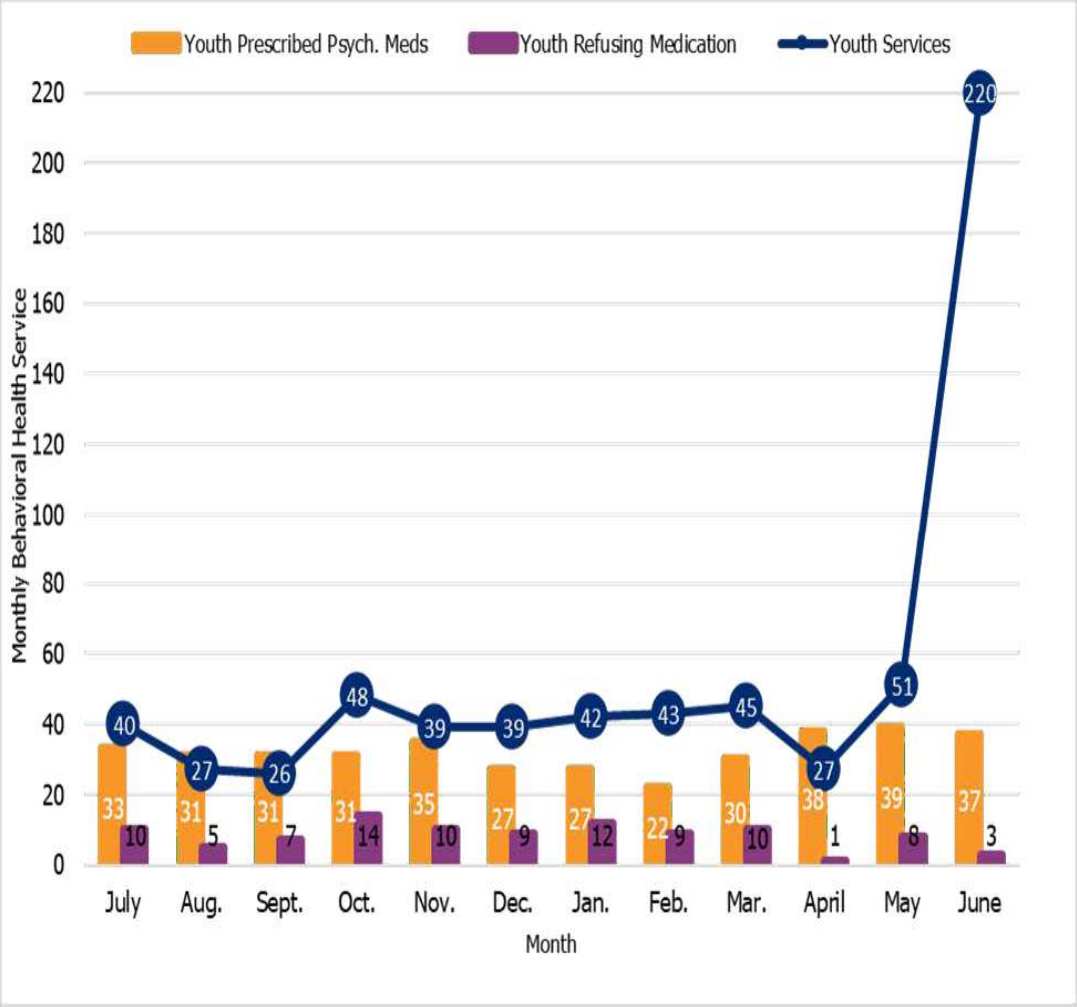
**Figure 2.** Number of Youth Receiving Behavioral Health Services in FY 23/24 by Facility Location



## Behavioral Health Medication Data

**Figure 3** illustrates the number of youth served monthly in behavioral health services during FY 23/24. The youth fluctuated between 26 and 220, with notable peaks in October and June. Monthly reports show that 22 to 39 youth were prescribed psychiatric medications, though a portion refused their medication at least once during the month; however, some of those refused their medications at least once during the month.

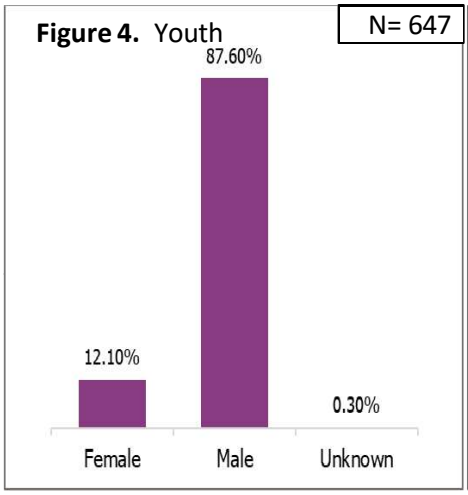
**Figure 3.** Number of Behavioral Health Cases, Youth Prescribed Medications, and Youth Refusing Medications, per Month

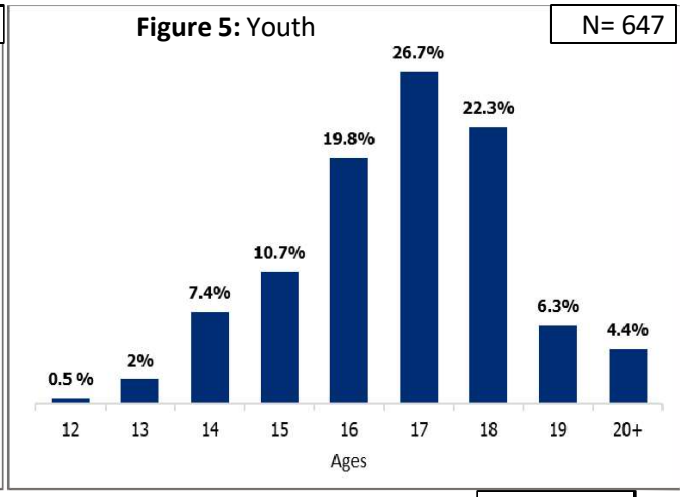


## Demographics

**Figure 4** shows that during FY 23/24, 87.6% of youth who received services were male, 12.1% were female, and 0.03% were unknown.

**Figure 5** illustrates the age distribution of youth served. 68.8% were between the ages of 16 and 18. The largest proportion was 17 years old (26.7%), followed by 16 years old (22.3%). This highlights that there was a concentration of services among older adolescents.

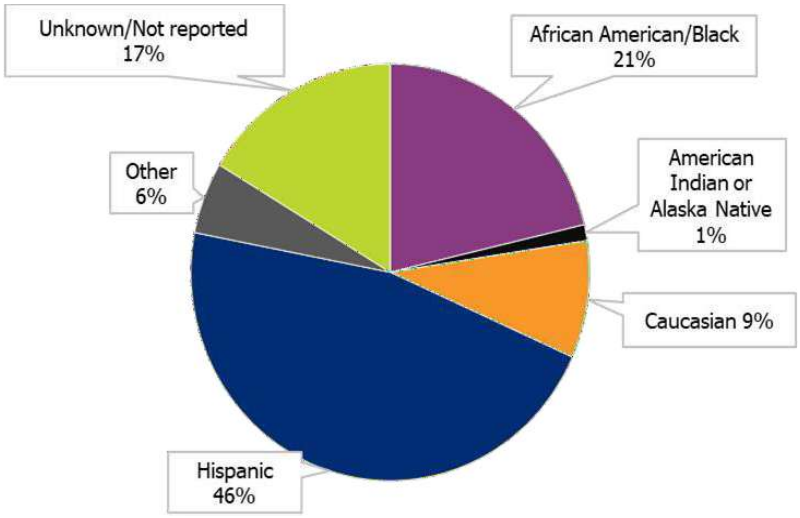



N= 647

Demographic data on the ethnicity of those served within FY 23/24 was gathered from the RUHS-BH electronic health record. As shown in **Figure 6**, the Hispanic/Latino (46%) was the larger group. The next largest reported ethnicities were African American/Black (21%) and 17% unknown/Not Reported. There is some disproportionality of those in Juvenile detention, and that is reflected in the race/ethnicity data for Black/ African American youth, which is a much larger proportion than the 6% of Black/African American youth in the overall County population.

**Figure 6.** Ethnicity of those Served




## Diagnoses

A total of 63% of the 838 youth who accessed RUHS-BH behavioral health services in FY 23/24 had new primary diagnoses available. Since some of the

Youth who were served in juvenile justice had been given more than one primary diagnosis record, and the most recent primary diagnosis is the one that is included in the data reported below.

As shown in **Figure 7**, the most common primary diagnoses were Personality Disorders and Impulse Control, accounting for 50% of the cases. Other prevalent diagnoses include anxiety and Other, both with 13%.

**Figure 7.** Primary Mental Health Diagnoses of those Served

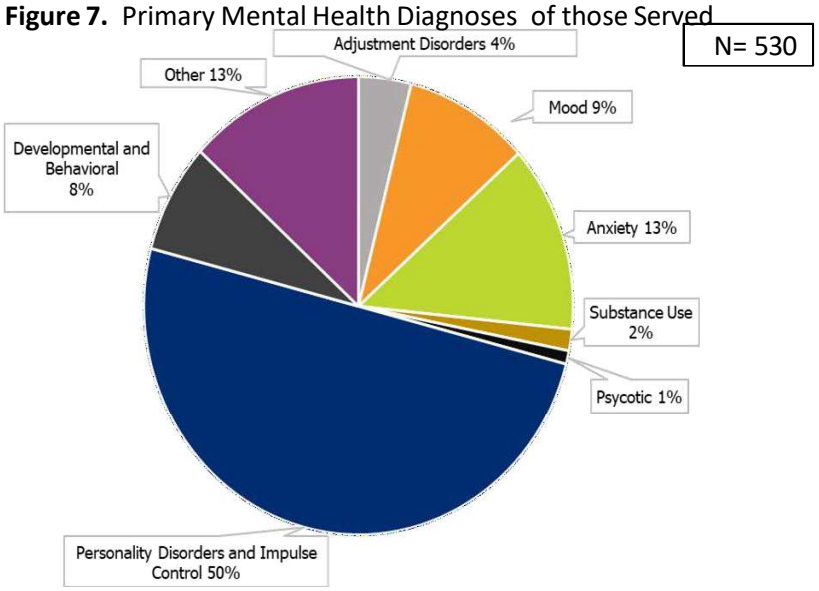
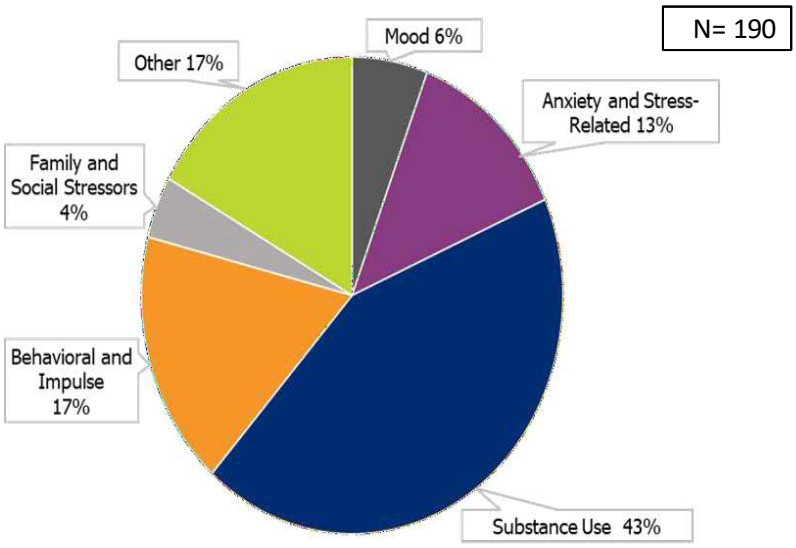



**Figure 8** highlights the Primary and Secondary Diagnoses of those youth served. Substance Use constituted the majority at 43%, followed by Behavioral and impulsive (17%) and Anxiety and Stress- Related (13%).

**Figure 8.** Primary and Secondary SUD Diagnoses of those Served




## Service Data

As shown in **Figure 9**, data from the RUHS-BH electronic health record shows that half (72%) of the behavioral health services were provided on an individual and group basis, with case management (14%) being the next most common service provided. Client support services and Psychiatrist Services represent only 0.1% since they had only 9 through 10 services in FY 23/24.

| Service Categories | Description |
|---|---|
| Assessment | Clinical assessment services (non-medication-related) |
| Psychiatrist Services | Medication-related services, including medication evaluation |
| Individual Services | Individual sessions with the client and client's family/ non-family |
| Group Services | Group |
| Crisis Services | Crisis intervention (75 minutes or more) |
| Case Management | Case management |
| Client Supportive Services | Other supportive services |

**Figure 9**. Services Provided by Category

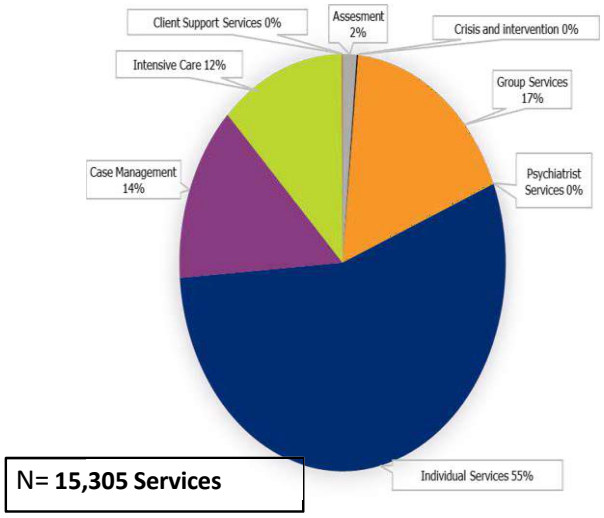
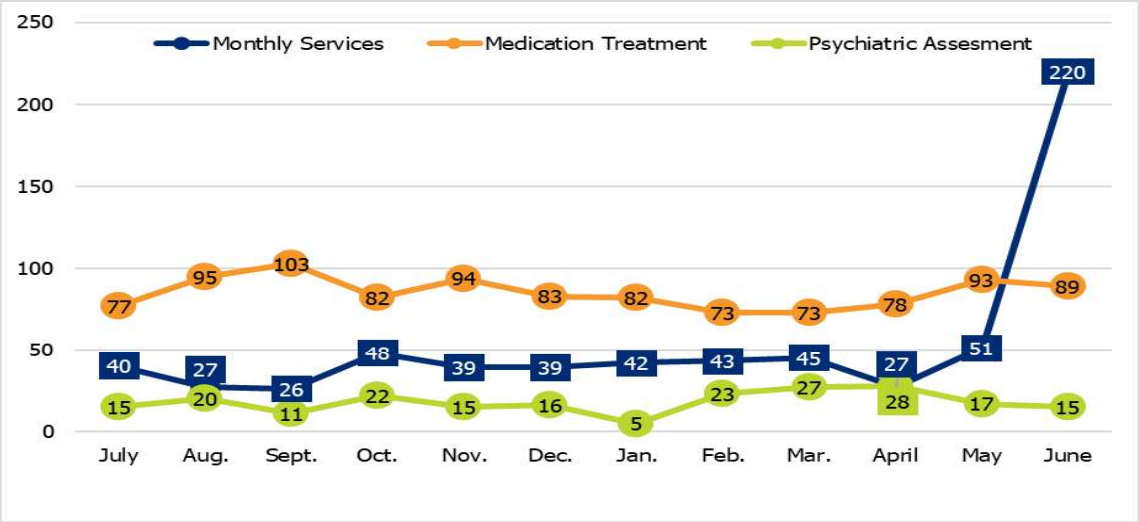


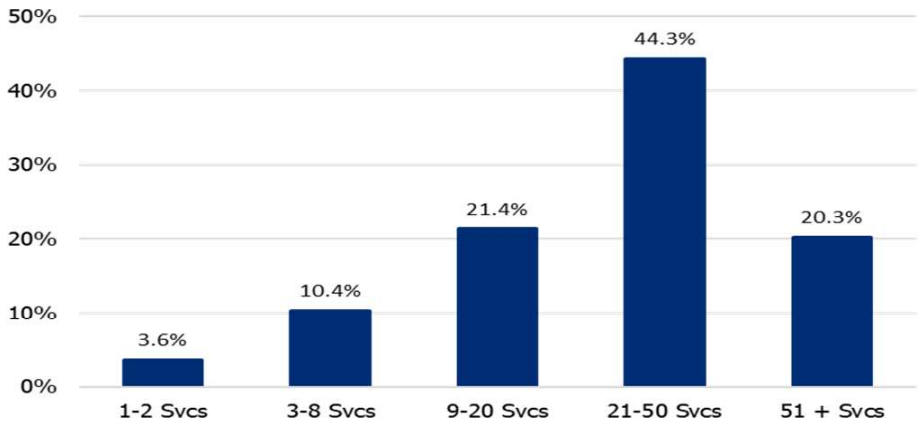
**Figure 10** shows that monthly Psychiatric Assessment ranged from 5 to 17 while the medication treatment ranged from 73 to 108 treatments this according to the RUHS-BH electronic health records.

**Figure 10** . Number of Psychiatric Services by Month




The number of services each youth receives is influenced by the duration of their stay at Juvenile Hall. As shown in Figure 11 below, 44.3% of youth received between 21 and 50 services, while 20.3% received more than 51 services. Additionally, according to the RUHS-BH electronic health records, 35.4% of the services were combined from 1 to 20 services.

Figure 11. Number of Services Provided to Youth at Juvenile Halls




The hours of service that each youth receives are affected by the duration of their stay at the Juvenile Hall. Figure 12 below shows that 41.5% of the youth received 31+ hours of services. This was followed by 21 to 30 hours, with 23.1%, and 11 to 20 hours, with 16.9%. A combination of 1 to 10 hours had a total of 23% of services that youth received.

Figure 12. Hours of Service Provided to Youth at Juvenile Halls

## Service Data YTEC

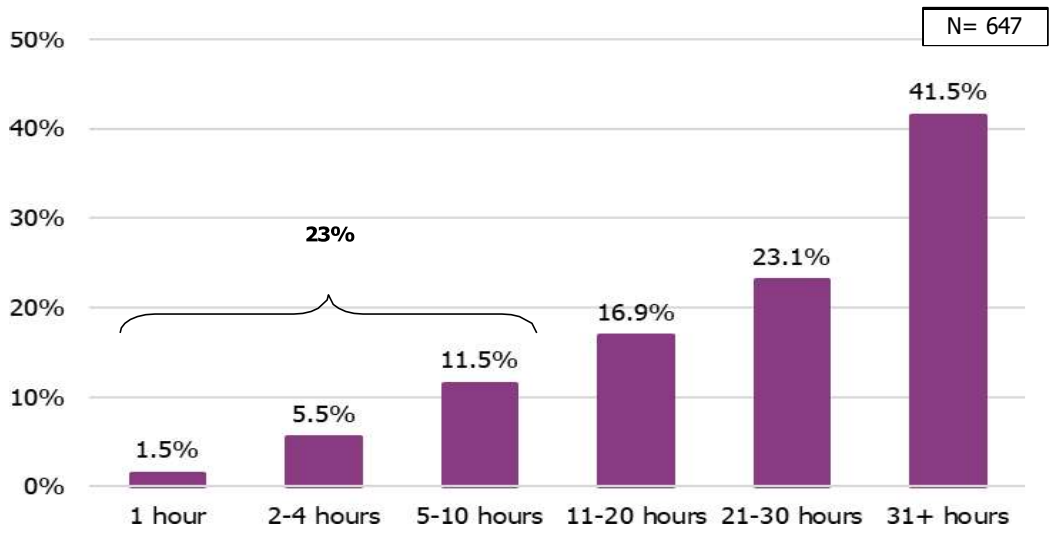



**Figure 13** illustrates that 92.3% of youth receiving services at YTEC during FY 23/24 received 21 or more services, according to RUHS-BH electronic health records. Specifically, 62% of youth engaged in 51 or more services, while 29.7% received between 21 and 50 services. Overall, fewer youth accessed lower service levels through FY 23/24, with only 7.7% receiving 20 or fewer services in the year.

Figure 13. Number of Services Provided to Youth at YTECs

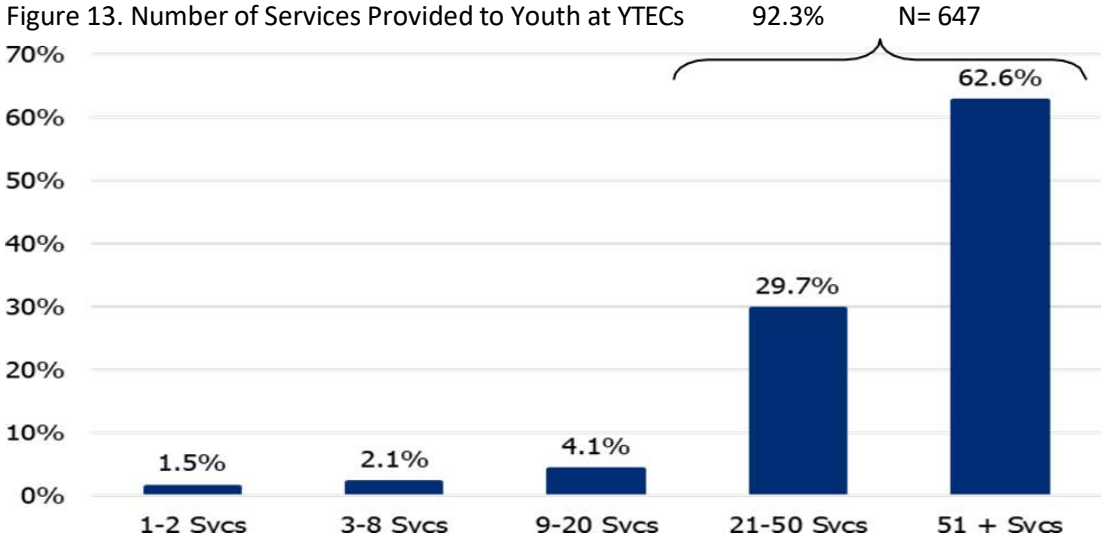
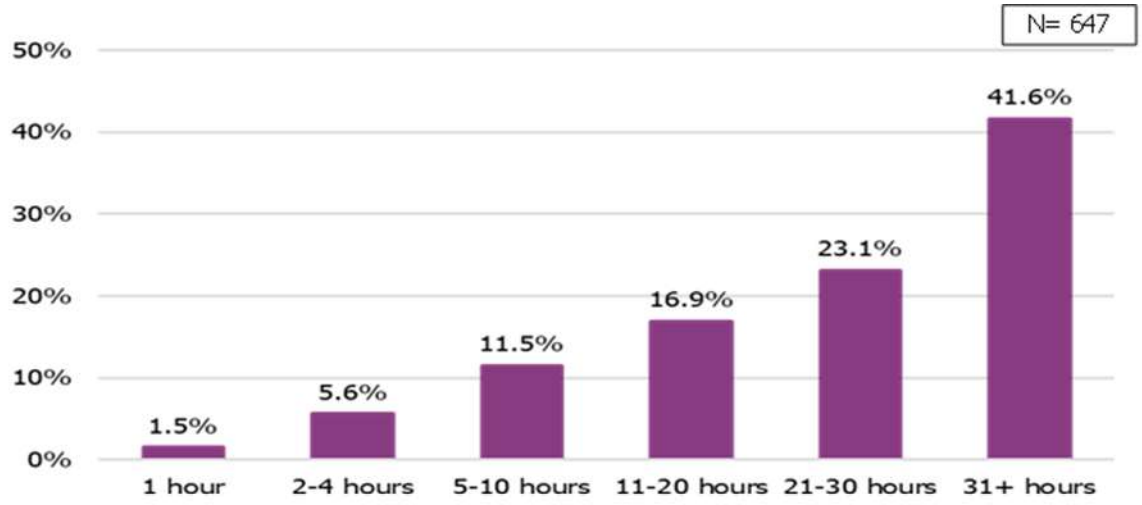



Figure 14 highlights the duration of services provided to youth. Among the participants, 41.6% received 31 or more hours of services, followed by 23.1% receiving 21 to 30 hours of services. Smaller percentages of youth received sorter services durations, with 5.6% receiving 2 to 4 hours and only 10.5% receiving just one hour of services

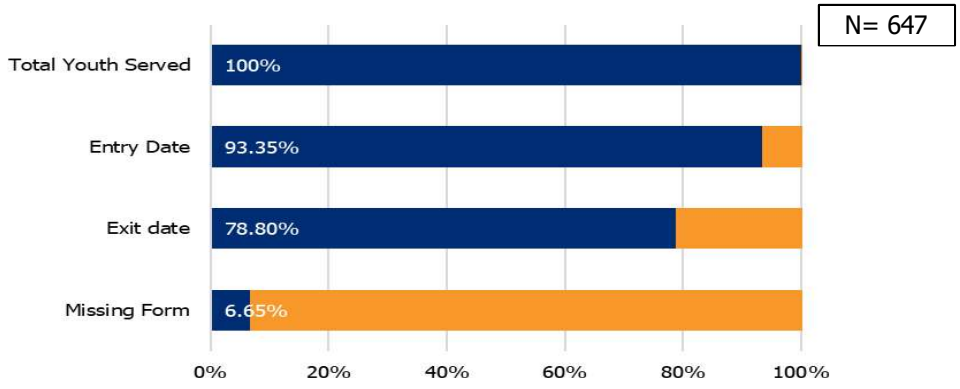
Figure 14. Duration of Services




## Behavioral Health Services After JVH/YTEC

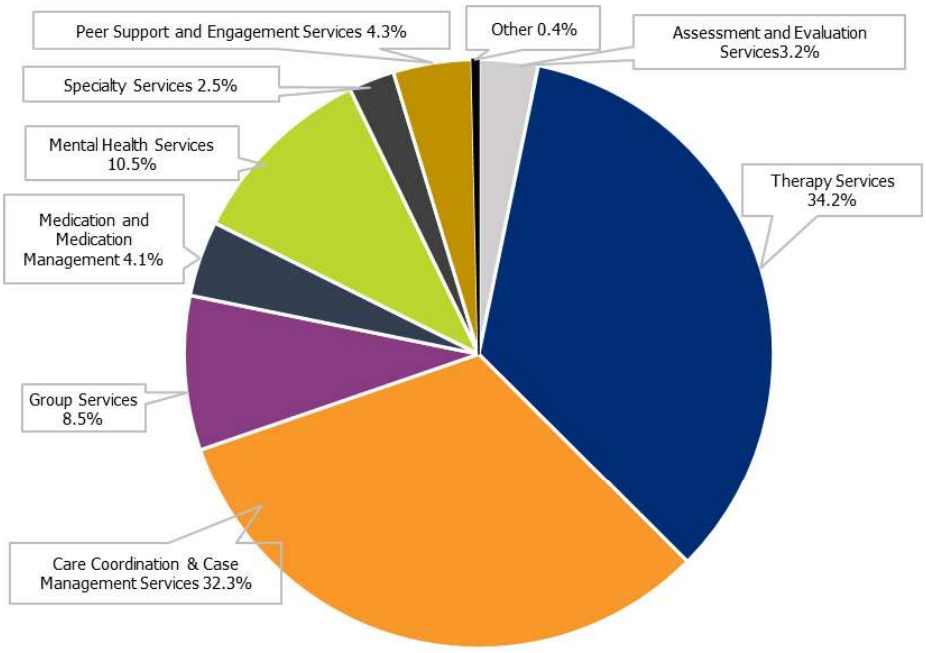
**Figure 15** shows that out of the 647 youth served during FY 23/24, 604 individuals had a program entry date in a Mental Health outpatient program, representing 93.35%. Among those, 476 had a closure date, accounting for 78.80% of closures for youth with both entry and exit dates. However, 43 youths were excluded from this calculation as they were not seen in the outpatient system following their JVH/YTEC Mental Health Services discharge. The total close percentage was 73.57% complete closure.

Figure 15. Percentages of youth with Entry and Exit form




Out of the 647 youth served in Juvenile Hall and/or YTEC, 85.8% received behavioral health services at an outpatient RUHS-BH program within 120 days of their last service in custody. Only 7.5% received services during the same period but from the last service day in custody. However, 43 youths were not seen in the outpatient mental health system. According to the RUHS-BH electronic health record (Figure 14), from those who received services, most of the services provided were Therapy Services (34.2%) and Care Coordination & Case Management Services (32.3%), while Specialty Services (2.5%) and Other (0.4%) had fewer services

Figure 16: After Services by Category




## Consults: Risk Behaviors / Crisis Issues

RUHS-BH provides Juvenile Justice behavioral health services related to risk behaviors. According to the monthly service report, 0 to 4 School Threat Assessment and Response (STAR) Reports were conducted each month, for 12 reports in FY 23/24, with an average of 1 report per month (See **Table 4**).

**Table 4:** Youth with STAR Protocol per Month

| | July. 2023 | Aug. 2023 | Sept. 2023 | Oct. 2023 | Nov. 2023 | Dec. 2023 | Jan. 2024 | Feb. 2024 | Mar. 2024 | April. 2024 | May. 2024 | June. 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Suicide Watch Consults** | 17 | 4 | 6 | 23 | 26 | 31 | 10 | 11 | 4 | 14 | 11 | 9 |
| **Safety Cell Consults** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Physical Restraint Consults** | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **4011.6 Consults** | 0 | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| | July. 2023 | Aug. 2023 | Sept. 2023 | Oct. 2023 | Nov. 2023 | Dec. 2023 | Jan. 2024 | Feb. 2024 | Mar. 2024 | April. 2024 | May. 2024 | June. 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **STAR Reports** | 0 | 0 | 4 | 2 | 1 | 0 | 1 | 2 | 1 | 0 | 1 | 0 |

## *GSD: Adult Detention*

Behavioral Health – Detention Services provided or offered discharge planning services to over 7,726 consumers during this reporting period. Approximately **1,440 consumers** received Behavioral Health services within **60 days post-release**, reflecting a slight increase from the previous year's total (**N=1400**). Among them, **3.04% (N=336)** were linked to **Full-Service Partnership** services.

Behavioral Health – Detention Services has also expanded its **Medication-Assisted Treatment (MAT)** program to include **Buprenorphine** alongside **Methadone**, partnering with a community **Opioid Treatment Program** to enhance medication treatment options. In collaboration with **Correctional Health Services**, individuals entering custody with an existing MAT prescription (**Buprenorphine or Methadone**) are permitted to continue their medication after being booked into custody. Additionally, those at **high risk of relapse** or experiencing **moderate withdrawal symptoms** can be **initiated on Buprenorphine** as part of their treatment.

Upon release, consumers receive **MAT referrals**, **Narcan Nasal Spray** with education on its administration, and a **five-day prescription** to support their transition to a **Narcotic Treatment Program**. In **Fiscal Year 2023–2024**, Behavioral Health provided MAT medications to **1502 consumers**. As services expand to meet the clinical needs of all eligible individuals, this number is expected to rise significantly.

Behavioral Health – Detention Services remains committed to exploring **innovative and effective strategies** to address the needs of its population. As treatment services grow, the goal remains to provide **critical resources** to those with the greatest needs, ensuring **successful reentry and continuity of care**.

A. **7,726 unique inmates with discharge services (9,612 bookings)**
   - 2,501 unique inmates with discharge planning progress note (2,911)
   - 441 unique inmates with discharge planning group note (460)
   - 7,226 unique inmates offered discharge planning services during MH screening (8,996)

B. **2,070 unique inmates received either individual or group therapy (18,916 services)**
   - 669 unique inmates received individual therapy (1,592)
   - 1,939 unique inmates received group therapy (17,324)

C. **1,502 unique inmates administered at least one dose of MAT classified medication (2,223 bookings)**
   - 1,205 unique inmates administered at least one dose of Buprenorphine HCl-Naloxone HCl Sublingual (1,845)

D. **12,101 bookings with BH service (9,856 unique inmates)**

| Row Labels | Count of ID | Percentage of ID D |
|---|---|---|
| Mild | 4653 | 38.45% |
| Moderate | 2449 | 20.24% |
| Severe | 1970 | 16.28% |
| None | 1945 | 16.07% |
| No Rating Provided | 593 | 4.90% |
| Stepdown_to_Moderate | 266 | 2.20% |
| Acute | 161 | 1.33% |
| Minimal | 64 | 0.53% |
| **Grand Total** | **12101** | **100.00%** |

- **11,071 releases with BH service (8,996 unique inmates)**
  - 336 (3.04%) releases linked to FSP services (based on the new episode)
  - 1,440 (13.01%) of releases linked to MH services within 30 days and 60 days (based on the new episode)
    - 1,210 (10.98%) of releases linked to MH services within 30 days

| Row Labels | Count of PATID | Percentage |
|---|---|---|
| Severe | 385 | 31.82% |
| No Rating Provided | 262 | 21.65% |
| Moderate | 212 | 17.52% |
| Mild | 150 | 12.40% |
| Acute | 112 | 9.26% |
| Stepdown_to_Moderate | 51 | 4.21% |
| None | 38 | 3.14% |
| **Grand Total** | **1210** | **100.00%** |

    - 230 (2.08%) of releases linked to MH services within 60 days

| Row Labels | Count of PATID | Percentage |
|---|---|---|
| Severe | 463 | 32.15% |
| Moderate | 282 | 19.58% |
| No Rating Provided | 273 | 18.96% |
| Mild | 201 | 13.96% |
| Acute | 112 | 7.78% |
| None | 55 | 3.82% |
| Stepdown_to_Moderate | 54 | 3.75% |
| **Grand Total** | **1440** | **100.00%** |

# CSS-03 Outreach, Engagement

Consumer Peer Services: Consumer Peer Services – Adult Consumers, Ages 18 & Up

**Consumer Peer Services Vision Statement:**

"We create doors, where walls and windows separate people from their promise of a life worth living. We usher in the whole person, their families, and their loved ones, recognizing their value, uniqueness, and the contributions they can make to their community. We promote an affirming environment that recognizes the gifts that all people possess by stepping away from old ways of thinking. Our knowledge and experience are sought to support the entire system to develop and sustain an environment that welcomes and inspires all who pass our threshold."

**Program Narrative**

Consumer Peer Services Program continued growth within the Behavioral Health Service System. The recovery model and consumer initiatives were implemented in cross-agency training and participation throughout the year. This is the priority of the Consumer Peer Services Program, which remained strong. Peer Support Specialists (PSS) are utilized in various areas and programs to integrate the consumer perspective into treatment teams within the behavioral health system. PSS are people who have experienced significant mental health and/or substance use challenges that have disrupted their lives over lengthy periods and have achieved a level of recovery and resiliency to use their recovery experience, benefiting others who experience behavioral health challenges. PSS has been added to existing programs and is used to develop innovative programs.

During this fiscal cycle, the Consumer Peer Services division continued the implementation of virtual Peer Support programming. The following are examples of how the PSS worked with the behavioral health system to meet those needs one-on-one and in group settings.

Outreach and Engagement: Consumer Peer Services

This reporting year, Consumer Peer Services has focused on the demand for increasing staff. We promoted line staff to fill vacancies in Senior positions and Consumer Peer Services, and added additional Senior Peer Support Specialists to support the entire Department with the following additions:

- SAPT - Desert Region

## *Peer Operated Programs*

Peer-Run Centers Summary:

**Peer Support & Resource Centers (PSRC)**

Peer Support and Resource Centers operated by RUHS-BH. Peer Support & Resource Centers operate in all three regions of the county. The PSRC provides an open recovery environment for adults and transitional-aged youth (TAY) where they can explore a wide range of mental health and recovery-based services. The centers are consumer-operated support settings for current or past mental health consumers and their families needing support, resources,

knowledge, and experience to aid in their recovery process. Each location offers a variety of support services, including vocational, educational, housing, benefit resources, and activities to support the skill development necessary to pursue personal goals and self-sufficiency. PSRCs are a "step down" from the more intensive programs or levels of care as consumers work toward self-sufficiency and full community integration. This program engages individuals to take the following steps in their recovery process. The PSRCs assist consumers to become less reliant on the costlier Riverside County behavioral health services.

PSRCs also provide alternative levels of care to increase capacity and allow for a lower level in the continuum of care for the Integrated Service Recovery Center's Full-Service Partnership (FSP) clients. Peer-to-peer support continues to be a priority that stakeholders have identified. Peer Support and Resource Centers are a key component of the Peer Support Services Work Plan.

- Recovery-oriented classes are offered five days a week to anyone wishing to connect to natural and community supports.
- Three locations of the Peer Support & Resource Centers
- 261 unique individuals served FV 23/24

Western Region: Downtown Riverside serving 303 Unique Individuals (Staffing - 4 PSS/1 OA/1 SPSS)
2085 Rustin Avenue, Riverside

Mid-County Region: Temecula Re-opened 2/1/23 serving 58 unique individuals (Staffing 3 PSS/1 SPSS)
40925 County Center Drive, Suite 120, Temecula,

Desert Region: Indio – Serving 85 Unique Individuals (Half Staffed) (Staffing 4PSS/1 SPSS)
44199 Monroe Street, Indio, CA

**Medi-Cal Peer Certification Program**

Building Peer Leaders, A Medi-Cal Peer Support Certification Training (BPL) (Contracted with CalMHSA as a Medi-Cal Peer Support Certification Training Entity)

BPL was successfully re-developed to meet all learning domains as defined under DHCS guidelines for the Medi-Cal certification of PSS. Additional specializations of Family Member/Parent, Unhoused, Crisis, and Justice-Involved training are also provided under contract with CalMHSA.

RUHS-BH and CalMHSA under contract – RUHS-BH Peer Education & Training Team has provided the following training to Riverside County Peer Support Specialists during FY 23/24:

- 101 individuals for Initial Medi-Cal Peer Support Certification
- 0 individuals for Justice-Involved Specialization – 27 Pending 2/2024
- 24 individuals for Family Member/Parent Specialization
- 0 individuals for Crisis Specialization
- 174 individuals in Medi-Cal Code of Ethics

Peer Education & Training Team – 5 positions

- Peer Staff Development Officer
- One Line Staff PSS for Education Program
- Three Senior Peer Support Specialists

The Office of the Riverside Public Guardian has added Consumer Peer Services to their staffing pattern.

**RUHS-Medical Center Support**

Medical Center continues to call on Consumer Peer Services for individuals receiving palliative care who need extra support

- RUHS-BH Emergency Services
- Consumer Peer Services continues to support Emergency Treatment Psychiatric Hospital by supporting individuals of the Community who seek services with ETS/ITF to normalize the process with stigma reduction interactions and engagements.

MHSA Innovations Technology Suite – Help@Hand Collaborative – Sunset 2/2023

Under the MHSA Innovations Technology Suite, RUHS-BH Research & Technology and the Peer Support Services programs worked collaboratively with a cohort with 14 other counties to explore, plan, develop, and implement technology-based interventions to serve the community, focusing on several populations of focus: LatinX, Rural Communities, the Deaf & Hard of Hearing, Men over 45, LGBTQ+, TAY, and the Re-entry population. These efforts were part of a 5-year grant, where Peer Management and Research & Technology management worked together to meet the community's needs. The TakemyHand Team continues to work within the RUHS-BH system of care to provide the same services to the community.

The Peer Support Specialist Team (Senior PSS, 4 PSS and Peer Program Manager) were heavily involved in the following aspects of this peer-driven project:

- TakemyHand Live Peer Chat https://takemyhand.co – 2021 CSAC Challenge Award Winner
- TakemyHand Peer Operator Training and Marketing Development – Shared with CalMHSA and adopted by CalHOPE and San Francisco County
- A4i (App for Independence), a smartphone app that allows the person experiencing psychosis in the area of auditory hallucinations to see whether sounds are environmental or internal. The app also allows participants to participate in community social media and integrate their activities in the app with their therapy session. The Peer Support Team provided peer-to-peer onboarding of participants and training for clinical care teams in a pilot project – Goal Met
- The Peer Support Team contributed to County wide resource kiosk development, so consumer satisfaction surveys could be completed at the time of each clinic visit in real time and provided training on the use of the kiosk to clinic staff- Goal Partially met, we received some submitted surveys, staff do not seem to be driving consumers to the kiosks to complete surveys.
- The Peer Support Team was an integral part of the UCI Evaluation Team's data collection process for the project, and were the subject of several "spotlight" articles in the UCI Quarterly Evaluation Reports (e.g., LGBTQIAN2+ Spotlight and RUHS-BH TakemyHand Live Peer Chat, etc.) **Goal Met**
- The Peer Support Team began the first Digital Mental Health Literacy classes- – **Goal Met** by providing over 40 classes County wide in our SOC.

- The Peer Support Team developed the RUHS-BH Free Apps Brochure, early Marketing Materials and the Quarterly Newsletter- – Goal Met
- Help@Hand-related Outreach Events – In-person and Virtual - Goal Met

**Take My Hand Live Peer Chat**

In partnership with MHSA Administration and Research & Technology, the Peer Support Team assigned to the Technology Suite Project continues to work to reach all community members through the TakemyHand Peer Team with the website usable and accessible for the team to continue to develop and adjust training materials and peer support strategies within the scope of SAMHSA core competencies and sustain the integrity of the peer support practice while answering chats.

The Take My Hand Live Peer Chat launched in June 2021 as part of a Statewide technology-based intervention, part of the portfolio of applications in the Help@Hand Collaborative, to reach some of the most difficult-to-engage population groups in the State. During this evaluation period, the Peer Support Team struggled with staffing after the initial staffing structure of utilizing “borrowed” peers from clinics. During the project's rapid deployment, they returned to their assigned Peer positions within the County structure. During this fiscal year, TMH had an average of three (3) full-time Line staff PSS, one (1) Senior PSS, one (1) PSS Supervisor (Consumer Peer Services Program Manager), and one (1) Tech Team Supervisor (MH Services Program Manager) and various staff in Research & Technology assisting with the project. The project's goal is to be fully staffed with 5 full-time Peer Support Specialists and identify project funding sustainability as the funding source ended in February of 2024.

**Supporting the Peer Workforce**

Since 2006, the Consumer Peer Support Program has been steadfast in the pursuit of providing monthly training and support to the people whose job class is the only class in the RUHS-BH System to have self-disclosure as part of the job duties and expectations.

In this pursuit, Consumer Peer Support Leadership has successfully sustained monthly one-on-one supervision with Senior Peer Support Specialists and Monthly Group Training Supervision for all peer providers.

**Peer Support Line Staff Monthly Training & Support Meetings** occur at least once a month on a day preselected by the SPSS Team of the Program/Region and the line staff peers of the Program/Region. Each is a 2.5-hour meeting to train on the core competencies, values, and ethics of peer support, explore challenges, provide moral support, practice team building, and provide recovery-oriented education and staff development geared to drive full-time Peer Support Specialist staff to their core competencies of practice on treatment teams. The structured agenda has a recovery theme each month, and the training is oriented to the monthly theme. The goal of the training and education meetings is to increase the skill set and competencies of SAMHSA Core Competencies of Peer Support, National Practice Guidelines for Peer Supporters, and the Medi-Cal Code of Ethics for Peer Support Specialists in California as adopted by DHCS in July of 2021, in preparation of State Certification of Peer Support Specialists, and certificate renewal requirements.

**Senior Peer Support Group Supervision Meetings** occur each month in a 2-hour session, specifically for Senior Peer Leadership to share learning opportunities and resources, strategize approaches to mentoring line staff Peer Support Specialists (SPSS), and receive coaching and supervision in a group setting. Again, the meetings focus on Core Competencies and Foundational Principles of Peer Support.

**Senior Peer Support One-on-one supervision** occurs once each month or as needed. This is a thirty-minute to one-hour structured private supervision for the Senior Peer Support Specialist to receive individualized peer support leadership mentoring from the Consumer Peer Support Program Manager. Each session includes updates on program-specific progress and addresses areas of concern. SPSS staff have this opportunity to ventilate challenges, brainstorm solutions, identify growth areas, give and receive feedback, set goals, and plan for future activities. This supervision is focused on assisting the Senior Peer Leader to mentor Peer Support Specialist line staff, utilizing the SAMHSA Core Competencies for Peer Supporters.

**Operation Uplift**—Extended COVID-19 Response—The Medical Center continues to reach out to Consumer Peer Services to provide peer support services to patients and staff alike.

The Peer Support Services Team extended its presence at the RUHS Medical Center and ETS/ITF to provide additional support to staff and the people served at those locations to mitigate feelings related to anxiety and compassion fatigue under stressful and sometimes traumatizing working conditions.

The Peer Support Services division assembled a team to create an ongoing presence for staff but also was instrumental in supporting staff and people served alike. This service is extended to provide hospitalized community members in the Palliative Care Unit of the RUHS Medical Center, as well as supporting behavioral health consumers in Medical Center Inpatient Settings.

The Public Guardian's office requested support for conserved and 51/50-hospitalized community members with beds at the RUHS Medical Center. The Peer Support Services Team responded by creating a 51/50 Sitters Team. Working with hospital staff, Peer Support Specialists provided much-needed relief to nurses working in units with 51/50 holds.

The Emergency Psychiatric Treatment Services Center (ETS) requested support to consumers. Peer Support Specialists were deployed to provide comfort and support to these consumers for long waiting times as ETS census rose. This support is ongoing, with a partnership and exploration of permanent Peer Support Specialist roles in the units at ETS. - **GOAL MET**

RUHS-BH Peer Services continues to support Medical Center staff with peer support for staff bi-monthly and as requested by Medical Center Executive Team.

Progress has been made at the RUHS Emergency Treatment Services and Inpatient Treatment Services location to place three full-time Medi-Cal Peer Support Specialists to provide direct services in inpatient settings. Personnel Control Numbers have been approved. Meetings to promote recovery-oriented services and integration of peers on the clinical teams are slated for March and April 2024. **Goal Met.**

Senior Peer Support Expansion in WET and Cultural Competency

Statewide Collaboration Efforts

• Peer Support Services leadership and line staff continued participation in the CalMHSA Innovations Technology Suite Help@Hand Project Cohort, in partnership with RUHS-BH MHSA Administration and Research & Technology to bring experienced Peer Support leadership to the collaborative process at the State level. **Goal met**- MHSA Innovation project completed February 2024

- Provided mentorship and training to the leadership of Santa Barbara, Los Angeles, and Merced Counties as they grow their peer support programs locally
- Peer Support Service Deputy Director continues as a permanent member of the RUHS-BH Executive Team to bring the peer voice to the highest level of leadership in Riverside County
- Provided Emergency Operation Committee personnel training and support regarding mental health and substance use self-care for the Emergency Operations Committee or EOC members.
- Provided feedback and training materials to DHCS (Department of Health Care Services) for planning and technical support for Peer Support Certification.
- Provided subject matter expertise as a listening session facilitator for the DHCS Medi-Cal Peer Support Specialist Certification Program.
- Provided feedback and training to Riverside County contract providers wishing to increase or incorporate peer providers in their workforce.
- Provided feedback and training to Inyo, Santa Barbara, and Orange County on how to incorporate peer providers into their workforce.
- Participated in State Conferences to further widespread knowledge of the Peer Support evidence-based practices.
- Provided subject matter experts on Peer Support State Certification at the SCRP Conference
- Provided subject matter expertise for CIBHS exploring behavioral health equity

**Peer Opportunities**

Lived experience as a behavioral health consumer is a gift to be given back to the communities in which we live. People with lived experience can, and do, get better. With coordinated support and training, a person who struggles with behavioral health challenges can learn to be with people one-on-one or in a group setting, providing Peer Support. Any person with lived experience in treatment and recovery for a mental health and/or substance use challenge can take a pre-employment training course, provided free of charge to residents of Riverside County, RUHS-BH. These services were brought in-house with RUHS-BH, and this fiscal cycle included building peer leaders - A Medi-Cal peer certification training in preparation for the Peer Certification Program implementation with CalMHSA.

**GOALS - Consumer Peer Services**

To create an Anger Management Group Curriculum that adheres to the Peer Support Recovery Model to be delivered to consumers in all clinic and detention environments – GOAL MET - Taking Action to Manage Anger was launched during the last fiscal cycle. FY 21/22 Many clinics/programs utilized this group curriculum. -**GOAL MET**

To create an Eating Disorders Group Curriculum that adheres to the Peer Support Recovery Model to be delivered to consumers in all clinic and detention environments – Pending

To build upon Peer Support workforce numbers to increase peer provider presence in TAY, specifically in Children's Services System and Detention Environments – still pending- In the recruitment process of 10 additional TAY Peers now. **TAY Peers goal met**- Detention environments still pending

To create a new Peer Support Specialist category for individuals from the Deaf and hard-of-hearing community. To meet the needs of DHH individuals, RUHS-BH Consumer Peer Services is striving to penetrate this hard-to-engage community through peer support. Adding specific Peer Employment Training for DHH consumers to bolster the representation of this community in the peer workforce is still pending. Groundwork with the community liaison is ongoing.

To sustain a "Real Peer Chat" technology instead of leaning on existing Artificial Intelligence programming in smartphone applications and websites. In that creation, the bigger goal is to influence statewide peer support program growth, influencing other Counties to grow peer support programs that assist peer providers to adhere to SAMHSA Core Competencies for Peer Supporters – GOAL MET - with the deployment of the Take My Hand Live Peer Chat under the Innovations Tech Suite Help@Hand Program. A Take My Hand Live Peer Chat smartphone application is currently in production and will be released to the community in the next fiscal cycle. As the Help@Hand statewide collaborative sunsets, Consumer Peer Services and the Research & Technology division are looking to sustain the project after MHSA Innovations funding is concluded. - **GOAL MET**

As a carry-over from FY20/21 Bilingual Spanish PSS Services. With the addition of our new Spanish Language Senior Peers, we will be moving forward to focus energies to the Spanish-speaking community to support and provide more recovery-oriented services in Spanish – This goal was partially met with the hiring of 2 new Senior Peer Support Specialists who are Spanish speaking and will be working to convert all group curricula county vast to Spanish.- In process

Add a new level of Executive Leadership to the Consumer Peer Services Program by creating a Deputy Director position that oversees all Peer Support Services county-wide, to create a structure of training and support for all areas of peer work. This role would provide full oversight of training and compliance of peer support practice for all Adult Consumer Peer Support Specialist and Family Advocates, TAY Peer Specialists and Parent Partners in Children's Services. – **GOAL MET** - with the hiring of the first Deputy Director of Peer Support Services

To increase the Peer workforce by having a minimum of 2 Peers in each of our Behavioral Health and SAPT clinics to serve the community better. Progress made.

Due to capacity restraints of an ever-increasing workforce of peers County Wide positions of SPSS to program-specific and regional vs. simply regional, as we have found the area of Riverside County is too vast to serve efficiently and effectively under the previous model. We have partially met this goal FY21/22 by hiring an additional Senior Peer for SAPT programs. The Consumer Peer Services Program Manager aims to hire additional Senior Peer Support Specialists for Crisis HHOPE and Children's (TAY) ensuring RUHS-BH has region-specific Senior Peers to meet the needs of specific programs. - **GOAL MET**

To retire the “Consumer Affairs” name and unit umbrella from RUHS-BH, and to create one system that supports all disciplines of peer support within the RUHS-BH system of care, the Peer Support Services division. – This goal is partially met by starting the groundwork to rebrand the division and its collaborative efforts. – Progress made.

To minimize and eventually alleviate peer discipline silos. RUHS-BH has a history of sustaining separate programs within the peer support workforce. Peer Support Services is an integrated system that needs to be created as one system instead of completely, separately operated disciplines of peer support. The isolation of each discipline (Consumer Peer, Family Advocate & Parent Partner) has created a lack of inter-disciplinary collaboration and threatens the success of all lived experience peer workers to pass the California State Certification exam. RUHS-BH Peer Support Services understands that all peers practicing peer support under the State Plan will be held to a set of core competencies and a code of ethics required by the State. Efforts have begun to create an integrated team in the Program Management Leadership Team, communicate to the system of this intent, and move forward on training to staff to accomplish this goal. **GOAL MET**

To create a specific interactive Peer Support Services webpage within the new www.ruhealth.org website that provides peer support resources and access to all disciplines of peer support, integrated with all service system programs. **GOAL MET**

To advocate for salary rate increases for line staff PSS, SPSS, and Peer Program Managers, now that State Certification is required, Riverside County has opted in to the State Plan. **GOAL MET**

To incorporate a Staff Development Officer into the Peer Workforce to oversee the Education and Training Program and be the Peer Support and Resource Center staff's onsite supervisor. **GOAL MET**

To expand the leadership team to include a separate Peer Supervisor for the Peer Support & Resource Centers to transition the Staff Development Officer into the sole role of SDO by the end of the three-year plan. **GOAL MET**

To launch the Medi-Cal Peer Support Certification Program by grandparenting all qualified PSS and SPSS current staff and starting the initial certification process for those who do not qualify. **GOAL MET**

To become a CalMHSA Training Entity to provide Medi-Cal Peer Support Certification Training, not only for State certification purposes but also to provide CalMHSA-approved supplemental training in the areas of specialization (Family/Parent/Caregiver, Justice-Involved, Unhoused, and Crisis). GOAL MET

To build capacity for peer support services, recruit staff, and re-open the Temecula Peer Support & Resource Center (**GOAL MET**), and to open three additional Peer Support & Resource Centers regionally placed to increase access to peer support recovery services for individuals not yet engaged in traditional services, or were former behavioral health consumers seeking additional support, education and resources to build upon their recovery. Expansion goal In progress

To update BH Policy 164 – Recruitment, Training & Promotion of Peer Support Specialists to include new language that would change job classification, address the Medi-Cal Peer Support Specialist Certification process, and give new guidance to staff around training and promotion processes**. GOAL MET** – BH Policy 164 has been updated in December 2024.

To establish new job classes more aligned with Medi-Cal Peer Support Certification, seeking automatic promotion for Peer Support Trainees who pass the Medi-Cal Peer Support Certification exam and to change the current job class of Peer Policy & Planning Specialist to Peer Program Manager, as their role in the Department represents. **GOAL MET** - The job class of Peer Policy & Specialist has been upgraded to Peer Program Manager.

To plan develop and launch a peer support workshop for RUHS-BH Medical Center Staff, Supporting Each Other – Peer Support Skills for Healthcare Workers. **Goal in progress**. Training curricula developed and approved.

**Contracted Programs**

In downtown Riverside, RUHS-BH contracts with RI International to provide peer support and art education in a studio environment. The program "Artworks" Peer Support Specialists provide ongoing support and hands-on assistance to people working toward recovery and resiliency goals with the use of painting, creative writing, multi-media art, crochet and quilling. These services are also offered to area clinics and programs to include art-focused recovery groups, facilitated by Peer Support Specialists.

## Parent Support and Training Program: Clinic/Program Parent

The Riverside University Health System – Behavioral Health, Parent Support and Training (PS&T) program was established in 1994 with the aim of developing and promoting client and family-directed nontraditional supportive mental health services for children and their families. The program was created in response to the many obstacles confronting families seeking mental health care for their children and aims to ensure that treatment and support are comprehensive, coordinated, strength-based, culturally appropriate, and individualized.

PS&T programs have been developed across the country to ensure that mental health services for children are family-centered and parent-directed. The program recognizes the importance of engaging and respecting parents and caregivers from the first point of contact. Parents want to be recognized as part of the solution rather than the problem, and PS&T aims to empower them in the care of their children.

The PS&T program emphasizes the importance of meaningful partnership and shared decision-making between parents and staff at all levels. By integrating the parent perspective into the system, services can be improved to better meet the needs of families. The program's strength-based approach recognizes the unique strengths of each family and works to build upon them, rather than focusing solely on deficits or weaknesses PS&T programs provide a range of services, including education, advocacy, and support to parents and caregivers, as well as mental health services to children. These services are culturally appropriate and individualized to meet the specific needs of each family. PS&T programs aim to ensure that families have access to the resources they need to help their children achieve their full potential.

The program emphasizes the importance of family-centered and parent-directed care and works to empower parents and caregivers in the care of their children. By integrating the parent perspective into the system, services can be improved to better meet the needs of families, and children can receive the support they need to achieve their full potential.

**Leadership/Coaching -** Newly hired Parent Partners are provided training and orientation that includes: How to Facilitate a Support Group; Orienting Parents to the Behavioral Health System; Educate, Equip and Support Facilitator Training; and Nurturing Parenting Facilitator Training. The training is also made available to Parent Partners employed by partner agencies, such as the Department of Social Services, contract service providers, and other community-based agency partners. All trainings/meetings are open to all Parent Partners working within a multitude of systems. Training topics include: Recovery Skills; Telling the Family Story; and Working within the County System as an Employee/Volunteer. A newly implemented training is our Parent Partner supplemental training. The specific content of this supplemental training focuses on more advanced topics, specialized skills, or additional tools and resources to enhance the Parent Partners' ability to support and engage with their peers. It's a positive step to invest in the ongoing professional development of Parent Partners, as it can lead to a more skilled and knowledgeable support network for the community.

There is a monthly county-wide meeting for all Parent Partners (Peer Support Specialists, with Parental/Caregiving of a Minor or TAY aged youth lived experience). There is also a weekly regional Parent Partner meeting to discuss region-specific concerns and to offer additional support. The meeting generally includes a roundtable discussion and updates from each clinic

as well as training and presentations on specific topics. Presentations are provided by both County and contracted providers with topics such as: Community Care Reform (CCR) Implementation, mobile crisis services, Operation SafeHouse, HHOPE (housing), Confidentiality, Mandated Reporting, Team Building, Boundaries, Strengthening Families, CANS and Documentation for Parent Partners. Parent Partners countywide participated in the UACF and UC Davis Parent Partner trainings. Countywide Parent Partner meetings now have an official training component providing opportunities for Parent Partners to earn continuing education credits for their State Peer Certification and are now offered in person or online (hybrid).

**Clinic/Program Parent Partners -** Parent Partners are hired as County employees for their unique expertise in raising their own child with special needs. At clinic/program sites, in coordination with clinicians, the Parent Partner will work directly with assigned parents, families, and child caregivers whose children receive behavioral health services through the Riverside University Health System – Behavioral Health system of care. Activities include parent-to-parent support, education, training, information and advocacy. This enhances parents' knowledge and builds confidence to actively participate in the process of treatment planning at all levels. Evidence-based programs/classes (listed above) are also provided by Parent Partners at clinic sites. The current number of Parent Partners countywide is approximately 126 including our contracted providers. We have Parent Partner who speak Spanish and one who speaks Punjabi.



**Partnerships/Collaboration**

PS&T program has continued to partner with the Department of Public Social Services (DPSS) and Probation regarding Pathways trainings for new staff. PS&T along with DPSS have incorporated the changes in both systems to ensure that all children entering the child welfare system are receiving mental health services as needed. This is the avenue, though which, parent and family voices continue to be heard in both systems. PS&T continues to attend Team Decision Making (TDM) and Child Family Team (CFTM) meetings to be a part of the process and a support to the families. PS&T attended 124 CFTM meetings for families. In 23/24, PS&T also was the Provider for DPSS Parent Referrals of approximately 2,500 parents that were referred through DPSS/ACT.

In FY 23/24, PS&T collaborated with Substance Use, Probation and Juvenile Detention programs to provide Triple P parenting classes. 215 parents participated in Triple P through our continued partnership with the Family Preservation Program. 50 parents at the Day Reporting Center (Probation) participated in parenting classes.

PS&T will continue to be a part of the Crisis Intervention Training (CIT) for law enforcement, as a part of the panel presentation, to provide the parent perspective when a child is experiencing a mental health related crisis response from law enforcement.

Parent Support is now partnering with the Youth Training Education Center (YTEC) program through probation in order to provide Parenting classes to youth who are parents and in placement through the Youth Training Education Center. Additionally, we are collaborating

with Probation on a Parenting Support and Resource team for families preparing for their youth to return home from placement through SB 823.

**Parent Support and Training Administration**

The Parent Support & Training Program is an essential component of Children's Services, designed to provide families with the necessary support and resources to navigate the challenges of raising a child with special needs. One of the most unique aspects of this program is the employment of Parent Partners - individuals who have personal experience raising a child with special needs.

Parent Partners are hired as County employees for their unique expertise and firsthand knowledge of families' challenges and obstacles when raising a child with special needs. These individuals bring a wealth of knowledge and insight into the program, which allows them to connect with families on a deeper level and provide invaluable support and guidance.

The Parent Support & Training Program Manager for Children's Services is responsible for overseeing the Program and ensuring that the parent/family perspective is incorporated into all policy and administrative decisions. The Program Manager works in close partnership with Children's Services Administrators to ensure that the program meets families' needs and provides the highest quality of care.

In addition to the PS&T Program Manager, the program is also staffed by Senior Parent Partners, Parent Partners, a Volunteer Services Coordinator, a secretary, and an Office Assistant. Each Senior/Lead Parent Partner is assigned to a different region of the County to collaborate with the regional Children's Administrator, Children's Supervisors, and regional Parent Partners. They provide coaching and guidance to the regional Parent Partners to ensure best practices while working with families.

The Parent Support & Training Program is an essential resource for families raising children with special needs. By employing Parent Partners and ensuring that the parent/family perspective is incorporated into all policy and administrative decisions, the program can provide families with the support and resources they need to navigate the challenges of raising a child with special needs. Parent Partners are individuals who have firsthand experience with navigating county systems as a parent or caregiver. They play a vital role in supporting other parents going through similar experiences by providing them with information, resources, and emotional support.

One of the agencies that Parent Partners work with is the Department of Public Social Services (DPSS). DPSS provides various services to families, including financial assistance, food assistance, and employment services. Parent Partners can help families navigate these services, provide information on eligibility requirements, and offer support as they go through the application process.

Parent Partners also work with the Probation department to support families involved in the justice system. They can provide parents with information on their legal rights, help them navigate the court system, and connect them with resources that can support their child's rehabilitation or their own.

Parent Partners also collaborate with community centers to offer parenting classes and other educational programs. These classes can cover a range of topics, from child development and behavior management to self-care for parents.

Parent Partners can facilitate these classes, drawing on their own experiences as parents to provide practical advice and support.

Parent Partners work with Children and Youth Mental Health Clinics to provide families with mental health education and 1:1 support. They can help families understand their child's diagnosis, navigate the behavioral health system, and access appropriate services and supports. Additionally, Parent Partners can offer emotional support to parents who may be struggling to cope with their child's behavioral health needs.

Parent Partners play a critical role in supporting families across multiple agencies and programs. By offering a range of services, including parenting classes, mental health education, and 1:1 support, they can help families navigate the child welfare system and access the resources they need to thrive.

The Parent Support & Training Program also employs Senior/Lead Parent Partners who are designated to work with specific populations. These Senior/Lead Parent Partners have specialized expertise in working with families who have unique needs and challenges.

One example is the Senior/Lead Parent Partner who is assigned to “Pathways to Wellness” and works closely with Child Welfare Partners to identify the needs of families. This individual plays a critical role in advocating for the needs of families and ensuring that their voices are heard in the decision-making process.

Another Senior/Lead Parent Partner is housed at one of the Transitional Aged Youth (TAY) Drop-in Centers, (Stepping Stones) working collaboratively with both parents of TAY and TAY who are parents themselves. This Senior/Lead Parent Partner provides support and guidance to these individuals, helping them navigate the challenges of parenting while also dealing with their own unique needs as young adults.

The Parent Support & Training Program also employs a Senior/Lead Parent Partner who is assigned to the Housing Program and works with homeless families. This individual provides critical support and resources to families who are facing the challenge of homelessness, helping them secure safe and stable housing and providing support throughout the process.

In addition, a Senior/Lead Parent Partner is assigned to the Cultural Competency Program, working to engage parents and families of different backgrounds and cultures. This individual plays a vital role in ensuring that services are accessible and inclusive for all families.

Senior/Lead Parent Partner is assigned to several schools in the Hemet Unified School District, assisting students and their families in connecting to necessary resources. This individual plays a critical role in helping families navigate the educational system and ensuring that students receive the support they need to succeed.

Senior Parent Partner has been assigned to SAPT and DRC programs countywide. Facilitating Parenting Classes, providing support to parents in the MOM’s program and Plan of Safe Care and Family Preservation Court.

This fiscal year 23/24, Parent Partners worked to link over 250 families and TAY with our housing partners. Parent Partners within the Administration unit provide support to the

broader community as well. In FY23/24 PS&T reached out to over 3,000 clients including Parents, TAY Youth, community members, and staff with needed information and resources to better advocate for their children, family members, and people they serve.

Services provided include:

**Parent-to-Parent Telephone Support Line**

The Parent Support & Training Program offers a countywide parent-to-parent support line to provide non-crisis support and education to parents and caregivers who live in Riverside County. This support line is a toll-free 800 number that parents can access for free. It provides an accessible and convenient way for parents to seek support and information without having to attend a support group.

The parent-to-parent support line is staffed by trained Parent Partners who are parents of children with special needs themselves. These Parent Partners are uniquely qualified to provide support, empathy, and guidance to other parents who are experiencing similar challenges.

The support line is available in both English and Spanish, ensuring that all parents can access the support they need regardless of their language preference. Parents can call the support line to ask questions, seek advice, or simply connect with someone who understands what they are going through.

The parent-to-parent support line is a valuable resource for parents who may feel isolated or overwhelmed by their parenting responsibilities. It provides a safe and supportive space for parents to discuss their concerns and receive guidance from experienced Parent Partners. The support line is open during regular business hours, Monday through Friday.

**Open Doors Support Group in English and Spanish**

The Parent Support & Training Program provides a countywide support group for parents and caregivers who are raising children or young people with mental health, emotional, or behavioral challenges. This support group is open to the community and provides a safe place for parents to share their experiences, receive support, and connect with other parents who are going through similar challenges.

The support group is available in both English and Spanish, making it accessible to all parents and caregivers in Riverside County. The group is facilitated by trained Parent Partners who have firsthand experience raising children with special needs. These Parent Partners provide guidance, empathy, and support to group members as they discuss their concerns and seek solutions to the challenges they face.

The support group provides a space for parents to share resources and information, brainstorm solutions, and support one another in their parenting journey. Group members can ask questions, seek advice, and receive validation and support from their peers. The group also provides an opportunity for parents to develop friendships and social connections with others who understand their experiences.

Due to pandemic era restrictions, classes were provided in a virtual environment.

**UPDATE**: Open Doors Support group is now in person in both English and Spanish. We have added an Open Doors Support group for TAY aged parents as well. Our newest support group is our Autism Support group which is designed to support parents who have children with Autism Spectrum Disorder.

**FY 2023/2024**

Current Group locations:

• Open Doors Riverside (Community Parent Support)

- Open Doors Riverside – Spanish (Community Parent Support)
- Open Doors Riverside, TAY parent Support (community parent support)
- Autism Support Group (Community Parent Support)

Resource Library - Offers the opportunity for Department or community members to check out videos and written material, free of charge, to increase their knowledge on a variety of mental health and related topics, including, but not limited to advocacy, self-help, education, juvenile justice, child abuse, parenting skills and anger management. Materials are available in both English and Spanish.



**Outreach and Community Engagement –**

The Parent Support & Training Program is committed to reducing stigma and building relationships through community networking and outreach. This effort involves providing educational materials, presentations, and other resources to community members, with a focus on access for culturally diverse populations. By engaging, educating, and reducing disparities in access, the program aims to create a more inclusive and supportive community for families raising children with special needs.

In the fiscal year 23/24, the program participated in 80 outreach events countywide. Where we reached out to 3,701 parents, youth, staff and community partners. We provided behavioral Health workshops about parents and children, presentations to staff and community partners.

Community networking and outreach are essential for reducing stigma and building relationships within the community. By providing educational materials, presentations, and other resources, the Parent Support & Training Program helps to educate the public about mental health and behavioral challenges. The program also works to reduce disparities in access to services for culturally diverse populations, creating a more inclusive and supportive community for families.

**Outreach Events:**

- Back to School Backpack Project 1,500
- Thanksgiving Basket Food Drive 250 baskets delivered
- Snowman Banner Holiday Drive 2,200 gifts delivered countywide
- May is Mental Health Month Events Countywide
- Fall Festival (Children's Celebration) 250 participants
- Holiday Celebration for Families 75 participants

**Recovery Happens**

Evidence-Based Programs/Classes - The Parent Support & Training program is a vital resource for parents in the community, providing a variety of classes and trainings to support parents in their roles. The program has continued to offer these services at various locations in both English and Spanish, ensuring that all parents in the community have access to the support they need.

During the fiscal year 23/24 the Parent Support & Training program served a total of 4,000 parents in the community through its parenting classes. These classes covered a range of topics, including child development, effective communication, positive discipline, and stress management. The program recognizes that parenting is a difficult job, and it aims to provide parents with the skills and knowledge they need to navigate the challenges that come with it.

In addition to parenting classes, the program also offered parent workshops, which were attended by 300 parents in the community during the fiscal year 23/24. These workshops covered specific topics in more depth, such as building resilience in children, managing challenging behaviors, and supporting children with special needs.

The program also provided educational presentations to the community, with a total of 1000 community members attending these presentations during the fiscal year 23/24 These presentations covered a range of topics, including mental health, substance abuse prevention, and community resources for families.

• Educate, Equip, and Support (EES): Building Hope - The EES education program consists of 13 sessions; each session is two hours and offered only to parents/caregivers raising a child/young person with mental health and/or emotional challenges. Classes are designed to provide parents/caregivers with general education about childhood mental health conditions, advocacy, and parent-to-parent support, and community resources.

• Triple P (Positive Parenting Program) - Triple P is an evidence-based parenting program for parents raising children 0-12 years-old who are starting to exhibit challenging behaviors.

• Triple P Teen – Triple P Teen is an evidence-based parenting program for parents raising young people that are 12 years and older.

• SafeTALK - Most people with thoughts of suicide invite help. Often these opportunities are missed, dismissed or avoided, leaving people feeling more alone and at greater risk. SafeTALK training prepares participants to help by using TALK (Tell, Ask, Listen, and Keep safe) to identify and engage people with thoughts of suicide and to connect them with further help and care.

• Nurturing Parenting - An interactive 10-week course that helps parents better understand their role. It helps to strengthen relationship and bonding with their child, learn new strategies and skills to improve the child's concerning behavior, as well as develop self-care, empathy and self-awareness.

• Strengthening Families – A 6-week interactive course that focuses on the Five Protective Factors. The Five Protective Factors skill-building helps to increase family strengths, enhance child development, and manage stress.

• Mental Health First Aid Youth – Teaches participants to offer initial help to young people with the signs and symptoms of a mental health condition or in a crisis, reviews the unique

risk factors and warning signs of mental health challenges in adolescents ages 12-18. It emphasizes the importance of early intervention and help to adolescents in crisis or experiencing a mental health challenge, and connects them with the appropriate professional, peer, social or self-help supports.

• Parent Partner Supplemental Training - This is a course for parents/caregivers of minor children to navigate mental health, and other systems, to better advise their children. It includes parent-specific peer support practices to prepare parents for possible employment opportunities as Parent Partners in the RUHS-BH system.

• NEW Nurturing Fathers Program – NFP is an evidence-based, 13-week course designed to teach parenting and nurturing skills to men. Each 2 ½ hour class provides proven, effective skills for healthy family relationships and child development.

Special Projects - Donated goods and services benefit children and their families with basic needs such as food, clothing, hygiene items, holiday food baskets, school supplies, gift certificates, as well as cultural and social events. In 23/24 the following projects provided resources to families:

• 20th Annual Back to School Backpack Project: 500 backpacks were distributed to young people at clinics/programs.

• 20th Annual Thanksgiving Food Basket Project:250 food baskets were distributed to families. An additional 22 Holiday meals were distributed as well.

Special Projects (Continued)

• 20th Annual Holiday Snowman Banner Project: 2,200 snowflake gifts were distributed to young people in clinics/programs.

Volunteer Services – PS&T recognizes the importance of community involvement and volunteerism in promoting positive outcomes for young people and their families. We have developed a robust program to recruit, support, and train volunteers from the community, including family members who are engaged in services.

The PS&T Volunteer Coordinator plays a critical role in this process. As a bilingual/Spanish speaker, they are able to reach out to and engage with a diverse range of community members. They coordinate special projects that focus on culturally diverse populations, ensuring that volunteers are equipped with the cultural competency skills necessary to effectively work with these populations.

In terms of recruitment, PS&T actively reaches out to members of the community who may be interested in volunteering. This includes young people who are looking for ways to give back to their community as well as parents who have benefited from the organization's services and want to give back in a meaningful way. PS&T recognizes that volunteers from the community bring a unique perspective and skillset to the table, which can be invaluable in supporting the organization's mission.

Once volunteers are recruited, they are provided with ongoing support and training. This includes regular check-ins with the Volunteer Coordinator to ensure that volunteers are comfortable in their roles and have the resources they need to succeed. Additionally, PS&T provides training to ensure that volunteers have a solid understanding of the organization's mission, as well as the skills necessary to effectively support young people and families.

Volunteering with PS&T provides both parents and young people with an opportunity to "give back" to their community. This not only benefits the community at large but can also be a transformative experience for the volunteers themselves. For young people, volunteering can help them develop valuable skills, build their resume, and give them a sense of purpose and meaning. For parents, volunteering can be a way to deepen their connection to the organization, while also providing them with a sense of fulfillment and accomplishment.

In F/Y 22/23, PS&T had 20 youth volunteers assisting at events 2 parent volunteers working alongside our office assistant, and 1 TAY youth who has dedicated over 200 hours of continuous service.

**Workshops/Trainings**

Workshops and trainings that focus on parent/professional partnerships and engagement can provide valuable information to staff, parents, and the community about how to effectively collaborate and advocate for services and supports for children with mental health needs. These trainings often include a parent's perspective to address the barriers that parents may face when advocating for their child's mental health needs.

These workshops also address the barriers that parents may encounter when advocating for their child's mental health needs. For example, parents may face challenges in navigating complex systems of care or may feel intimidated or overwhelmed when communicating with mental health professionals. These trainings can provide information and support to parents, empowering them to advocate effectively for their child's needs.

In addition to providing information on parent/professional partnerships and the parent's perspective, these workshops can also address specific topics related to the provision of mental health services to children and families.

**GOALS FOR Parent Support and Training**

The Parent Support & Training Program is a vital resource for parents, caregivers, and youth in providing education, support, and resources to navigate the challenges of parenting. The program recognizes the changing needs of families and seeks to adapt its services accordingly.

• To continue providing services to parents, caregivers, and youth in a safe and accessible manner. As the pandemic has forced many activities to move online, the program has adapted to ensure that its services remain available virtually. This approach has allowed parents, caregivers, and youth to access services from the comfort of their homes, reducing barriers to participation.

• To keep "COVID babies" in mind. Children born during the pandemic have unique needs and experiences that require special attention. The program recognizes the importance of providing support to parents and caregivers of COVID babies and ensuring that they have access to resources that can help them navigate the challenges of parenting during a pandemic.

• Millennial parents have also been identified as a priority population for the program. This generation of parents faces unique challenges related to work-life balance, financial instability, and the pressures of social media. The program recognizes the need to tailor its services to meet the specific needs of millennial parents and provide them with the tools and resources necessary to raise healthy and resilient children.

• The program seeks to increase engagement with fathers. Fathers play an essential role in child development and parenting, but they are often overlooked or underrepresented in parenting programs. The program recognizes the need to engage fathers and provide them with the support and resources they need to be active and engaged parents.

• The PS&T programs will continue providing the services and support as the previous year as well.

• Homeless families are a continued and very important area of identified need in the community. Families and young people are more successful when housing stabilization is addressed for the entire family. There is a Senior/Lead Parent Partner assigned as a point person to homeless families, assisting to connect them to available housing. Laundry assistance has been a useful engagement strategy. PS&T has a contract with a laundromat to facilitate the ability for families to have continued access to clean clothing. PS&T has also implemented a "Boutique" where families can access a variety of clothing, essential items, and hygiene products when needed.

• One of the main barriers that continue to impact parents/caregivers is the transportation system in our County. PS&T provides classes/trainings to parents in their local area to overcome this barrier. Because of pandemic-era adaptations, we now have virtual capability and can offer a variety of classes/groups remotely.

• The children of parents who are incarcerated are often left out of services and not recognized as being in need. As the parents are released from jail, they transition to the Day Reporting Center (DRC). PS&T provides services on-site (both in person and virtually) at all three of the DRCs in Riverside, Temecula, and Indio. This allows for continuity in their services and facilitates the completion of the Triple P course. Additional services offered at the DRCs include: EES classes and Nurturing Parenting classes in partnership with several agencies that support the AB109 – New Life population.

• PS&T will continue collaborative efforts with the Department of Public Social Services and Probation regarding the Pathways to Wellness (Katie A.) and Continuum of Care Reform (CCR) for the transformation of mental health services to families within systems. PS&T will continue to collaborate on committees, and provide ongoing trainings to staff, community, parents, and young people that are involved with that system. PS&T continues to have a key role in upcoming Child, Family, and Team Meetings, and provides Intensive Home-Based Services to those families. An ongoing need that we are seeing with families, due to COVID-19, is an increase in anxiety, grief, and depression in the children in the community. This is an area of continued awareness and collaboration within the community and school districts for support to families.

• Parent Support & Training is currently advocating to add Parent & Family Support Centers located adjacent to, or within RUHS-BH campuses that provide crisis services to the public. Often, children are placed into care while in crisis inappropriately. The lack of beds for minor children in Riverside County creates challenges for both the child and family members who are seeking help for their child. A minor child can often sit in an Emergency Psychiatric Services Center or ED for hours, and sometimes days, without child-appropriate surroundings. The parents of those children need support when their child is experiencing a crisis, and Parent Partners would be instrumental in supporting the families during that difficult time. PS&T would like to see a minimum of three Parent & Family Support Centers open in the three

regions of Riverside County to provide real-time support, education, and resources, without having to wait for an appointment, when the crisis is developing. This drop-in model would serve families not necessarily engaged in services but provide the vital connections and support they need.

RUHS-BH PS&T is intended to assist families, regardless of whether they are receiving any type of formal mental health services. Assistance will be provided to identify needs, overcome obstacles, and actively participate in service planning for their child and family unit. Focused outreach to specific underserved groups is key. Focus given to African American families, homeless families, and prison-release parents will facilitate increased engagement through outreach, community events, and needed classes or programs (e.g.: anger management classes, building parental advocacy skills on behalf of their children as they navigate multiple public systems, etc.). The ultimate goal is to keep children safe, living in a nurturing environment, and with sustained connection to their families. This will help to avoid homelessness, hospitalization, incarceration, out-of-home placement, and/or dependence on the State for years to come.

## *Family Advocate Program*

The Family Advocate Program (FAP) assists family members to cope with and understand the behavioral health concerns of their adult family members through the provision of information, education, and support. Also, the FAP provides information and assistance to family members in their interactions with service providers and the behavioral health system to improve and facilitate relationships between family members, service providers, and the behavioral health system in general. The FAP provides services in both English and Spanish. Currently, FAP employs eight (8) Senior Peer Support Specialist – Family Advocates (Senior Family Advocate - SFA) and fourteen (14) Peer Support Specialist – Family Advocates (Family Advocate - FA) providing services throughout the three Regions in Riverside County (Western, Mid-County, and Desert). Peer Support is an evidence-based practice for individuals with mental health conditions or challenges. Family Advocate peer support is provided by individuals who self-identify as a family member/caregiver of an adult engaged in behavioral health services or community family member/caregivers who seek assistance with support and systems navigation before having their loved one introduced to available services.
The ten SFAs are assigned regionally to specific sites and countywide. Regionally: two in the Western region, two in the Mid-County region, and two in the Desert region.
Specific sites: one each serving in Lake Elsinore, Hemet, Temecula, San Jacinto, and Perris.
Countywide SFAs provide services with one each assigned to specialized areas: Forensics, Substance Abuse Prevention & Treatment (SAPT), TAY Centers (3 locations), and Outreach & Engagement. The SFA works in collaboration with clinical staff and provides leadership, mentorship, and guidance to FA line staff. The 14 FA line staff work directly with family members of consumers in several clinics, programs, and community sites within Riverside County. Family Advocate Program has added a Crisis email to interact with our Behavioral Health crisis teams. 244 referrals have been made and processed during this fiscal cycle.
The Family Advocate Program offers Support, Education, and Resources in the forms of:

**Support Groups**
During the height of the pandemic, the FAP responded by fortifying family support through virtual group offerings Countywide. FAP expanded group accessibility by over 100% by allowing the community to access a support group via Zoom 4 times a week, regardless of any clinic affiliation. Each group is formatted to provide a safe space for family members and caregivers to share their experiences, connect to resource information, and receive guidance through an educational process to assist the family member, in building skills, and promoting higher levels of wellness and recovery to the entire family unit.

- Sibling Support Group- All Regions- Online
- Taking Action to Manage Anger- Western- Mid County
- Coffee for the Soul / Café para el Alma- All Regions
- Substance Abuse Family Support- All Region- Online

• Family Planning for Success- All Regions
• Grupo de Apoyo Familiar- Mid County - Dessert
• Crisis Support for Families- All Regions
• Recobrando La Ezperanza- All Regions

Community Presentations

During this fiscal cycle, the FAP hosted numerous informational presentations to family members and the community on topics, including but not limited to:

• "Taking Action to Manage Anger for Families"
• "Empowering Families to Participate"

**Community Presentations (continued)**

• "Holiday Stress Management"
• "Coronavirus & Mental Health"
• "Advocacy Overview: Education, Support, Resources and Information"
• "Crisis Support Systems"
• "Families, Mental Illness and the Justice System"
• "Meet the Doctor". Through our "Meet the Doctor" series, the FAP collaborates with Riverside University Health System – Behavioral Health (RUHS – BH) psychiatrists to inform and educate families from a provider's perspective on topics such as medication adherence, sleep difficulties, the diagnosis of schizophrenia and bi-polar, among other topics.
• "Meet the Pharmacist"
• "Meet the Clinical Therapist"
• "The In's & Out of Conservatorship"
• "Meet Law Enforcement"

**Training**

FAP facilitates the following training courses for family members/ caregivers:

• Family WRAP (English and Spanish). Family WRAP is recognized by the Federal Substance Abuse and Mental Health Service Administration (SAMHSA) as an evidence-based practice.
• Family-to-Family (English and Spanish). The National Registry of Evidence-Based Practice (NREPP) listed Family-to-Family as an evidence-based practice.
• DBT for Families (English and Spanish)
• Crisis to Stability
• Real Recovery
• Mental Health First Aid. MHFA is a public education program that introduces participants to risk factors and warning signs of mental health concerns, builds an understanding of their impact and overviews common treatments and supports.

**Outreach**

FAP networks with community agencies through outreach at local universities, colleges, high schools, and middle schools, providing educational materials and resources to staff and students on mental health and stigma reduction. FAP attends health fairs, and shares information on trainings to culturally diverse populations. Outreach and engagement include May's Mental Health Month Fair, NAMI Walk, Recovery Happens, and numerous public engagements. The Outreach and Engagement Countywide SFA organizes all-inclusive

community mental health events for families to make interpersonal connections to the Mental Health System in Riverside County. FAP hosted its fifth annual "Family Wellness Holiday Celebration" (formerly known as "Posada") attended by approximately 100 family members from diverse communities in a virtual environment. Per community suggestion, the FAP in collaboration with NAMI will explore the implementation of other cultural adaptations of NAMI programs such as "Compartiendo Esperanza" for the Spanish-speaking community, as well as "Sharing Hope" model for the African American community. FAP assists in various anti-stigma campaigns where behavioral health outreach is not traditionally given, such as community centers and faith-based organizations. Outreach takes place in Veteran clinics and hospitals to provide information on NAMI Home Front, an educational program designed to assist military families care for a family member diagnosed with Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), and other diagnoses

Through Family Advocate presentations, trainings, and outreach efforts, RUHS-BH has learned the importance families place on information and education. Feedback surveys collected from family members/ caregivers show an overwhelming amount of requests for information and education.

Many of the families we serve find information and education important because of the role they play in caring for their loved ones.

Families shared their involvement in their loved one's care. Fifty-six percent reported scheduling and providing transportation to their appointments.

**Clinics/Sites**

The FA line staff members work directly with family members of consumers within their clinics, sites, and programs. FA line staff members are in various clinic settings as well as our crisis teams throughout the County. FA staff assist in enhancing family support services within the outpatient clinics and work directly with clinical staff to advocate for families' integration into treatment. FA staff provide support at the Blaine, Hemet, Corona Wellness, Lake Elsinore, Perris, Temecula, and Indio Adult Behavioral Health Clinics. By promoting the empowerment of family members, they are better able to assist in their loved one's road through recovery, as well as their own. FAs assigned to the Family Rooms emphasize the engagement of families in treatment by offering support, education, and resources to enhance the family member's knowledge and skills and expand their participation and active role in their loved one's treatment. The FAP continuously implements its commitment to providing support, education, and resources to families in the TAY Centers. Education, information, and engagement of parents, family members, and other supportive persons are included in the services and can receive supportive service from Family Advocates. Throughout Riverside County, FAs hold weekly family support groups, TAY family support groups, and a sibling support group. This includes providing individual family support to family members within the behavioral health system, as well as, in the community.– program active

**Justice-Involved**

FAP works with the Office of Public Guardian (PG) and Long-Term Care (LTC) programs to assist families within the judicial system, Diversion Court, Care Court, and Mental Health Court. Families experience increased struggles with understanding the complexities within the

criminal justice system, such as incarceration, criminal court proceedings, MH Court, Long Term Care, and Public Guardianship. The SFA assists families of individuals with justice involvement to navigate these programs, offering support, providing a better understanding of the system, and offering hope to their loved ones. This SFA provides support, resources, and education to families whose loved one has been placed on conservatorship and/or is at a Long Term Care Facility. This SFA also acts as a liaison between families and the programs to offer additional support and an understanding of the LTC and PG processes, Veterans Mental Health Court, and Detention. The State of California, Council on Criminal Justice and Behavioral Health (CCJBH), recognized the FAP for the support offered to families in the judicial system and its continued contribution to reducing recidivism rates. The FAP developed several family educational series, such as "Families, Mental Illness, and the Justice System", "My Family Member Has Been Arrested" and "The Conservatorship Process," in both English and Spanish to the library of presentations offered countywide to family members, providers, and the community. Family Advocates Program was recently approved to hire three-line staff Family Advocates to assist in the Forensics Programs to meet the increased needs of the community. Family Advocate Program has been tasked to participate in the California CARE Court Program. This program Rather than cycling through jails and emergency rooms, CARE Court gives vulnerable individuals and those who care for them another path to access key services that can help keep them safe. Family members, roommates, clinicians, and others can petition the court to seek approval for this program. Family Advocate Program has been able to support families of 41 participants in this fiscal cycle.

**Collaboration**

FAP attends and participates in several Behavioral Health Department Committees. Such as TAY Collaborative, Criminal Justice Committee, Behavioral Health Regional Advisory Boards, Adult System of Care, Veterans Committee, and Cultural Competency Committees, to ensure that the needs of family members are heard and included within our system. FAP is part of the Family Perspective Panel Presentations with several RUHS–BH programs and agencies, such as the Graduate Intern Field and Trainee (GIFT) program, Workforce Education and Training (WET) and the Crisis Intervention Team (CIT) training to Law Enforcement. The CIT training includes the family perspective when called upon to de-escalate a mental health crisis. The FAP remains the liaison between RUHS – BH and the National Alliance on Mental Illness (NAMI) to assist the four local affiliate chapters with the coordination and support of the NAMI Family-to-Family Educational Program and will facilitate classes in both English and Spanish as needed. FAP assisted the Riverside and Hemet NAMI affiliates to start the first two Spanish-speaking NAMI meetings in Riverside County. In partnership with the local affiliates, the Spanish NAMI meetings successfully provide much-needed support to our Spanish-speaking communities. Most recently, FAP in partnership with the Filipino American Mental Health Resource Center to engage, support, and educate family members on mental health services. FAP works in collaboration with the Cultural Competency Program outreach and engagement efforts in all three regions. The FA Program was recently approved to add an SFA to the Cultural Competency team to further the efforts within Riverside County.

Volunteers continue to be an essential part of the FAP. SFA mentor volunteers in the day-to-day activities of an FA line staff. Their activities include attending the NAMI Family-to-Family Education Program and family support groups. Under the direction of the SFA, volunteers, and interns are active in outreach and engagement of the underserved populations, as well as co-facilitating the NAMI Family-to-Family classes and family support groups. The FAP continues to join forces with Consumer Peer Services and Parent Support and Training programs to promote collaboration and foster growth in understanding family and peer perspectives.

**GOALS - Family Advocate Program**

In the upcoming fiscal year, The FAP proposes to increase its involvement and offer new educational support to families and expand services such as:
• Continue to increase Family Advocate Peer Specialist positions to other clinic sites and programs such as Substance Abuse clinics and TAY – GOAL MET – active support groups in all SAPT clinics, held in-person and on virtual platforms.

• Recovery Management for family members Goal Met- Senior Family Advocate SAPT Program has integrated recovery management for family members through outreach and engagement and monthly support groups. GOAL MET.

• Forensics' support groups – GOAL MET – held on virtual platforms Countywide.

• Have an active role in Mental Health Urgent Care – GOAL MET – Senior Family Advocate leads the Inpatient/Outpatient Collaboration Committee that meets monthly with MHUC, Emergency Treatment Services Staff, and BH Staff to troubleshoot challenges with transitions between levels of care and to collaborate within the teams to facilitate timely to services for the people we serve GOAL MET.

• Expand Family Advocate staff into the Crisis Residential Treatment Facility (CRT) – Pending

• Family Advocate providing support and education at the RUHS-Behavioral Health Moreno Valley Medical Center campus. Also, assist with discharge and after-care planning. Goal in progress – The Family Advocate Program has received referrals from the Medical Center Moreno Valley as an after-care process. – Pending

• Expand the collaboration with law enforcement to provide continued education to the community on how to interact with law enforcement on crisis calls. GOAL MET – Family Advocates participate each month in the Crisis Intervention Training with officers from Riverside PD and Riverside County Sheriff's Department. They charge their lived experiences and other insights for the participants. GOAL MET.

• Develop a Family Advocate Email that will be used to get more referrals from the community and County partners. GOAL MET – Crisis referrals for families are now directed to a Family Advocate email and are addressed daily. This service went live on June 28, 2023.

The FAP believes that recovery is essential in their support services to families. We provide support to the family members as they go through their recovery journey. With continued support, education, understanding, and self-care recovery is possible for all members of the family.

## *Veteran Services Liaison*

Riverside University Health System – Behavioral Health (RUHS-BH) offers veteran-specific services through our Veteran Services Liaison (VSL). The VSL provides outreach, engagement, case management, therapy sessions, and a commonality as a veteran to those who need services and support. Motivated by President Lincoln's Second Inaugural Address, RUHS-BH is dedicated "to care for him who shall have borne the battle, and for his widow and his orphan."

The VSL is a Clinical Therapist who serves as a portal to behavioral health care. After 2 years of recruitment for this specialized position, a candidate was selected in August 2024.

**Cultural Community Liaison, Felix Gbagbo**

The new Veterans Cultural Community Liaison and Clinical Therapist, Felix Gbagbo, MSW, began in August 2024. He joined the existing Riverside County Behavioral Health Commission's Veterans Subcommittee, attending their monthly meeting before being welcomed by the entire Commission at their public meeting on November 6, 2024. The Cultural Competency Program is excited to have a designated individual to assist Veterans with their behavioral health needs irrespective of their disability status, honorable or dishonorable status, targeting anyone who served our nation.

With approximately 112,000 veterans in Riverside County, Felix and the Veterans Subcommittee are committed to reaching as many veterans as possible to provide them with access to housing, veterans' benefits, and health resources. They also work to link them to and navigate the VA system, improving their well-being and quality of life.

**Accomplishments thus far:**

**Advocacy:**

Advocated on veterans' behalf to assist with accessing services, resources, and information relating to a higher level of care:

• Advocated for 5250 Psychiatry Hold for Convalescence/Nursing Home and Emergency Room veterans to improve their well-being and to receive the best care

- Financial resources to decrease the stress of potential homelessness for a wheelchair-bound veteran having challenges paying overdue utility bills by speaking with the Salvation Army and the Low Income Home Energy Assistance Program (LIHEAP) on the veteran's behalf; and

• Participated in a Veterans Day Discussion Panel at Temecula Adult Clinic to discuss topics on Mental Health Challenges for Veterans in the County of Riverside

**Networking:**

Gained additional contacts and learned more about existing services and resources by attending a series of events to network with County, non-profits, and government groups and individuals interested in serving the needs of veterans, including:

- Congressperson, Dr. Raul Ruiz, (Emergency Room Physician) Veterans University Event (Public Library, Hemet)
- Riverside County Veterans' Advisory Committee Meeting (American Legion Post, Riverside)
- BRIDGING THE GAP – Addressing Intersectional Health Disparities and Strengthening Support in the VETERAN COMMUNITY Meeting (Jurupa Valley)
- 2024 Veterans Expo hosted by Senator Kelly Seyarto (Murrieta)
- California Assemblymember, Dr. Corey Jackson (Peer Support Resource Center, Riverside), Veterans Care access and concerns discussion
- 12th Annual Veterans and Community Expo/Planning and Networking Meeting (Cathedral City)

**Outreach:**

Reached groups who support veterans and veterans directly, shared resources, and offered services and/or assistance in accessing services via resource tables at:

- Veterans Suicide Awareness event (American Legion, Indio), partnering with the RUHS BH Mobile Crisis Management and Response team
- Veterans Safety Standdown (National Guard Armory, March Air Reserve Base, Riverside), again partnering with RUHS BH Mobile Crisis Management and Response team
- 2024 Veterans Expo hosted by Senator Kelly Seyarto (Murrieta) to receive Mental Health educational resources for veterans

**Support:**

Provided therapy, transportation, assessments, resources, education, and collaborative care to veterans throughout Blythe, Indio, Banning, Temecula, Hemet, and Riverside:

- Veteran consumers seeking behavioral health care
- Transported veterans to and from the Medical Center Prosthetics Unit, Medical Centers, and Apartment Complexes to receive care and placement
- Collaborated care with a retired Army Sergeant 1st Class/Deacon, and an HHOPE Certified Peer Support Specialist to provide grief counseling
- Provided psychoeducation and resources to veterans at Rustin Peer Resource Center regarding Mental Health and navigating the VA System
- Partnered with the HHOPE Street Outreach team and the HHOPE Veterans Outreach team to house unsheltered/homeless veterans and to provide them with psychoeducation, therapy, and assistance with navigating the VA Disability Claims process

Felix Gbagbo has only just begun to honor the commitment he shares with the U.S. Department of Veterans Affairs, demonstrated by their March 2023 update to their mission statement, "To fulfill President Lincoln's promise to care for those who have served in our nation's military and for their families, caregivers, and survivors." As a Navy Veteran and Clinical Therapist, he is well-equipped to inform the Veterans Subcommittee to serve members and veterans in Riverside County.

# CSS-04 Housing

**Housing**

Homeless Housing Opportunities Partnership and Education (HHOPE)

Riverside University Health System – Behavioral Health continues to provide housing and homeless services to our department and the community at large through our Homeless Housing Opportunities, Partnership, and Education (HHOPE) program. HHOPE provides a full continuum of housing and homeless services. These include but are not limited to:

- Coordinated Entry System (CES): a 24/7 hotline and staff to assess and refer those in a housing crisis
- Street Outreach & Case Management
- Emergency Housing
- Rental Assistance
- Transitional / Bridge Housing
- Permanent Supportive Housing
- Augmented Adult Residential Facilities
- Enhanced Care Management & Community Supports

HHOPE staff support all elements of these programs including street-based and home-based case management, clinical therapy, peer support, and all administrative, compliance, fiscal, accounting and oversight activities required for program operations.

HHOPE Program provides resident supportive services to consumers residing in 706 supportive housing apartments/units across Riverside County, which incorporate various funding streams including, U.S Department of Housing and Urban Development (HUD), State California Department of Housing and Community Development (HCD), No Place Like Home (NPLH), and MHSA funds. HHOPE staff also support various landlords in the MHSA-funded apartments and our emergency shelter motel vendors to ensure safe and available housing options are secured. Our staff also support residents residing in our senior housing developments by providing transportation to and from medical appointments as needed, at no cost to the consumer.

Like other RUHS-BH programs, HHOPE benefits from Peer Support Specialists (PSS) to build consumer engagement and rapport. These staff have a lived experience of accessing the behavioral health system for their own need and have been homeless or have experienced a mental health condition and/or substance use disorder at some point in their lives. HHOPE employs PSS staff throughout all our various programs. Additionally, we have a Senior Peer Support Specialist who oversees multiple responsibilities and mentors our Peer Support Specialists. The PSS role is unique from our other staff as they provide lived experience, promote recovery from behavioral health challenges, provide resources to navigate the many systems of the County, and have an inside perspective of consumer struggles. Each of our

peers, including our senior peer, go above and beyond providing efficient services to ensure the needs of the community are met.

HHOPE serves as the County's lead agency for the Coordinated Entry System known as, Home Connect. The Coordinated Entry System (CES) provides a crisis response system, coordinates supportive services, and housing resources across Riverside County to form a collaborative, no-wrong-door system that connects households experiencing a housing crisis to services and housing. HHOPE continues to be very active in the development and operations of the CES program and works to ensure that individuals with disabilities are protected and treated equitably. HHOPE staff provides ongoing support and education to the community regarding the CES system capabilities and works to improve their operating system continually. In 23/24, CES has fielded over 21,107 calls for homeless assistance and has referred over 644 households for housing assistance/vouchers. Additionally, HHOPE CES staff continues to provide training on the County's homeless assessment, known and referred to as the VISPDAT, and has trained assessors who collected more than 5,370 assessments of homeless individuals/households.

The HHOPE program currently has 16 dedicated mobile homeless outreach teams, primarily composed of a Behavioral Health Specialist II and a Peer Support Specialist on each team. These teams are regionally assigned, providing street outreach and engagement, as well as housing navigation, landlord supports, and linkages to our MHSA services. These teams continue to be integral and are key players in the housing of homeless Veterans initiatives in our community as well as engagement of chronically homeless individuals and families. The Veterans initiatives resulted in Riverside County being awarded as the first large community in the nation to achieve functional zero for Veteran homelessness.

Recognized as innovative in our Housing Crisis program development and street engagement programs, RUHS-BH HHOPE continues to work in collaboration with city government and law enforcement to provide contractual street engagement in targeted areas for the Cities of Palm Desert and Menifee. The City of Menifee project, which began in 2021 and has experienced significant success, has resulted in an extension to provide outreach and engagement services through the end of June 2028. Utilizing an innovative Housing Crisis approach and housing plan development initiatives, these teams are key in linking those on the streets to our behavioral health services and system. HHOPE has also worked with local agencies to provide ongoing training to staff on homeless response program development and is working collaboratively with law enforcement agencies as they develop new homeless-specific services in their programs.

MHSA funding for temporary emergency housing and rental assistance was continued and further supplemented with grant funds from EFSP (Emergency Food and Shelter Program) and ESG (Emergency Solutions Grant) to provide access to emergency motel housing and/or rental assistance. These funds also help support our Housing crisis program, which includes homeless prevention services, which are also informed by a Housing First philosophy. Combined EFSP and ESG funds have provided over 50,915 bed nights of emergency housing for consumers in need for Fiscal Year 23/24.

HHOPE began a collaboration with the Family Advocate program to develop a Housing Resource specialist role with the Family Advocate program, to support and navigate our families through the challenges of a Housing Crisis, which can be overwhelming. This continues to be a valuable resource for the HHOPE program.

The HHOPE Program continues to support a unique community-based, very-low-demand permanent supportive housing project. The Path follows a low-demand, drop-in model for providing homeless outreach and permanent supportive housing to homeless individuals with serious mental health conditions. This residence operates through a contract with a nonprofit provider whose program model emphasizes peer-to-peer engagement and support. Those seeking permanent housing must have a diagnosed behavioral health challenge and be chronically homeless. The contractor employs a diverse staff, including Peer Support Specialist staff who may have received behavioral health services themselves, and many have experienced prolonged periods of homelessness. HUD permanent supportive housing grants partially fund the Path. All individuals referred to this housing program, must be referred through the County's Coordinated Entry System, Home Connect. The RUHS-BH HUD grants have been successfully renewed in order to support this program through FY 23/24

**The Path,** located in Palm Springs, opened in 2009 and provides permanent supportive housing for 25 adults. It is located immediately adjacent to a Full Service Partnership clinic operated by RUHS-BH. The Path maintained an occupancy rate of nearly 94.5% occupancy rate across the year.

The success of The Path, together with the prominent role it plays in the continuum of housing for RUHS-BH consumers, positions these programs for continued success as a valuable contact point for homeless individuals with severe mental illness.

RUHS-BH remains committed to serving the extremely high-barrier individuals including youth, adults and older adults who were formerly chronically homeless with severe and persistent mental health challenges. Many of those we serve are individuals who were high-utilizers of hospitals, jails, and Emergency Medical Services. By continuing to use the Housing First approach without precondition and coordinating matching care with our Full Service Partnership Behavioral Health Clinics we continue to expand our services and provide the needed supports for our target population. As well as proving on-site 24 hr. peer support staff, and 24 hr. on call support to our residents and landlords and a 24 hr. drop in center accessible to those on the streets and law enforcement to avoid incarceration, we were able to assist many residents who were previously some of the highest utilizers in our CoC to maintain stable housing. For FY 23/24, Four hundred and forty-seven (447) residents graduated to living in their own apartments of which two hundred and twenty (220) received no ongoing housing subsidy and the remaining two hundred and twenty-seven (227) received housing subsidy to assist with a portion of their rent.

The HHOPE Program's Mainstream Housing team assists qualified consumers in locating & maintaining housing. Consumers must be between 18-60 years of age with a documentable

disability, transitioning out of institutional or separated settings, or at serious risk of institutionalization, or homeless, or at risk of homelessness, low to no income, and currently receiving services through RUHS-BH clinics. Currently, we are assisting 92 households through this program to receive housing throughout Riverside County.

Both HHOPE Program teams and Mainstream are leveraging MHSA dollars to fund the staff who serve their clients with housing. The use of MHSA funding enables clients to benefit additionally from a Section 8 Mainstream 811. This produces a greater benefit for clients' housing for each MHSA dollar spent.

MHSA Housing Development One Time Funding: RUHS-BH has committed and expended all available MHSA housing development funds held in trust by the California Housing Finance Agency (CalHFA) and will continue to support affordable housing development and development projects as soon as funding becomes available. RUHS-BH leveraged MHSA funds for permanent supportive housing to support the development efforts associated with the creation and planning of more than units of affordable housing throughout Riverside County. Integrated within each MHSA-funded project were units of permanent supportive housing scattered throughout the apartment community.

The MHSA permanent supportive housing program continues to maintain stable housing for over 120 at-risk participants, with each MHSA-funded project consisting of 15 integrated supportive housing units within the larger complex. Each apartment community includes at least one full-time onsite RUHS-BH funded support staff with a dedicated office. Additionally, the HHOPE program staff support the tenants as well as wrap-around support for the landlord to help them with any complications they may experience. The MHSA apartment units operate at 100% occupancy and experience very little turnover, with an ongoing waiting list of more than 500 eligible consumers for housing of this kind. Existing units of MHSA permanent supportive housing will remain available to eligible residents for a minimum period of 20 years from the date of initial occupancy.

HHOPE started offering Enhanced Care Management (ECM) and Community Supports (CS) services in 2022. These two programs follow the CalAIM initiative, which is designed to improve the quality of life and health outcomes of Medi-Cal enrollees, including those with the most complex health and social needs.

ECM is one of the two new HHOPE programs developed which aims to improve Medi-Cal for people with complex needs and who are facing difficult life and health circumstances. ECM focuses on breaking down the traditional walls of health care by extending beyond hospitals and health care settings into communities. This program addresses clinical and non-clinical needs of the highest-need enrollees through intensive coordination of health and health-related services. ECM services meet clients wherever they are – on the street, in a shelter, in their doctor's office, or at home. Clients will have a single Lead Care Manager who will coordinate care and services among the physical, behavioral, dental, developmental, and social services delivery systems, making it easier for them to get the right care at the right time. We are excited about the addition of four Justice-Involved Enhanced Care Management

(ECM) teams to our program. These new teams will focus on providing critical support to individuals involved in the justice system, helping them navigate housing, healthcare, and other essential services. By expanding our ECM efforts, we aim to improve outcomes for justice-involved individuals, reduce recidivism, and promote long-term stability within our community.

Additionally, clients are being connected to Community Supports to meet their social needs, including medically supportive foods or housing supports. Community Supports are designed to address social drivers of health (factors in people's lives that influence their health). A key goal of Community Supports is to allow Members to obtain care in the least restrictive setting possible and to keep them in the community as medically appropriate. HHOPE is currently offering 6 of the 14 CS services available through managed care plans: Housing navigation, housing deposit, housing tenancy, recuperative care, short-term post hospitalization, and sobering centers.

HHOPE has been identified as one of the leading providers of supportive housing in our community and as such has provided ongoing consultation services and specialized training to other Behavioral Health staff and community agencies on landlord services and Supportive Housing best practices. HHOPE has provided additional program specific training provided to new PSH agencies. Our HHOPE Deputy Director has been a presenter at the National Alliance on Ending Homelessness, the nation's premier homelessness conference in both FY 18/19, 19/20, and 22/23. This type of platforms allows HHOPE to share learned experiences and educate others on the best service approach and best practices to support our population.

**Looking Ahead**

The HHOPE staff will continue to provide a unique Housing Crisis Response program with ongoing landlord and supportive housing supports throughout the community.
There are now 706 units of permanent supportive housing provided by the HHOPE program and delivered to behavioral health consumers in Riverside County. Permanent supportive housing, for people with a behavioral health challenge, remains an integral part of the solution to homelessness in Riverside County. The need for this housing continues to outpace the supply. While there remains much community uncertainty about the ability to expand upon the success of the MHSA permanent supportive housing program due to the loss of various state and federal funding, such as Redevelopment Agency funding in recent years (without any viable alternative), together with the continuing transformation of the complex financial structures that are necessary to develop affordable housing, we continue to press forward and seek every opportunity to provide needed housing opportunities. There are ongoing efforts to collaborate and join with developers and community partners to capture any funding opportunity that will support the production of affordable housing, which includes units of permanent supportive housing for MHSA-eligible consumers. One such effort is the No Place Like Home Program.

On July 1, 2016, Governor Brown signed landmark legislation enacting the No Place Like Home program to dedicate up to $2 billion in bond proceeds to invest in the development of permanent supportive housing for persons who are in need of behavioral health services and

are experiencing homelessness, chronic homelessness, or who are at risk of chronic homelessness. The bonds are repaid by funding from the Mental Health Services Act (MHSA). Key features of the program include:

- Counties will be eligible applicants (either solely or with a housing development sponsor).
- Funding for permanent supportive housing must utilize low barrier tenant selection practices that prioritize vulnerable populations and offer flexible, voluntary, and individualized supportive services.
- Counties must commit to provide behavioral health services and help coordinate access to other community-based supportive services."

The HHOPE program in collaboration with Riverside County Housing Authority submitted five separate applications to California Housing and Community Development in the amount of $27,688,025 for No Place Like Home (NPLH) Round 1 funding. RUHS-BH was funded for four of these projects for a total award of 23.6M dollars. Round 1 of funding created 162 new units of permanent supportive housing within a total of 419 extremely affordable apartment units. These four projects are now complete and open for occupancy. RUHS-BH also applied for Round 3 and 4 of NPLH funds and was awarded 55.1M dollars for the development of eight additional permanent supportive housing projects. Two of the eight projects are now complete and open for occupancy. Two projects are expected to open in May and June and the remaining four will open between now and the Summer 2026.

**Goals**

1. HHOPE will diligently work to end homelessness and provide for the housing needs of the individuals we serve.
2. Expand ECM and CS services to serve more households
3. Continue to create innovate and customer service friendly CES tools to improve consumer experience
4. The program anticipates opening the Franklin Residential Care Facility and Behavioral Health Clinic in the next year. This 84 bed facility in Riverside will provide recuperative care and board and care services to adults with severe and persistent behavioral health diagnoses.

# Section III

## PEI

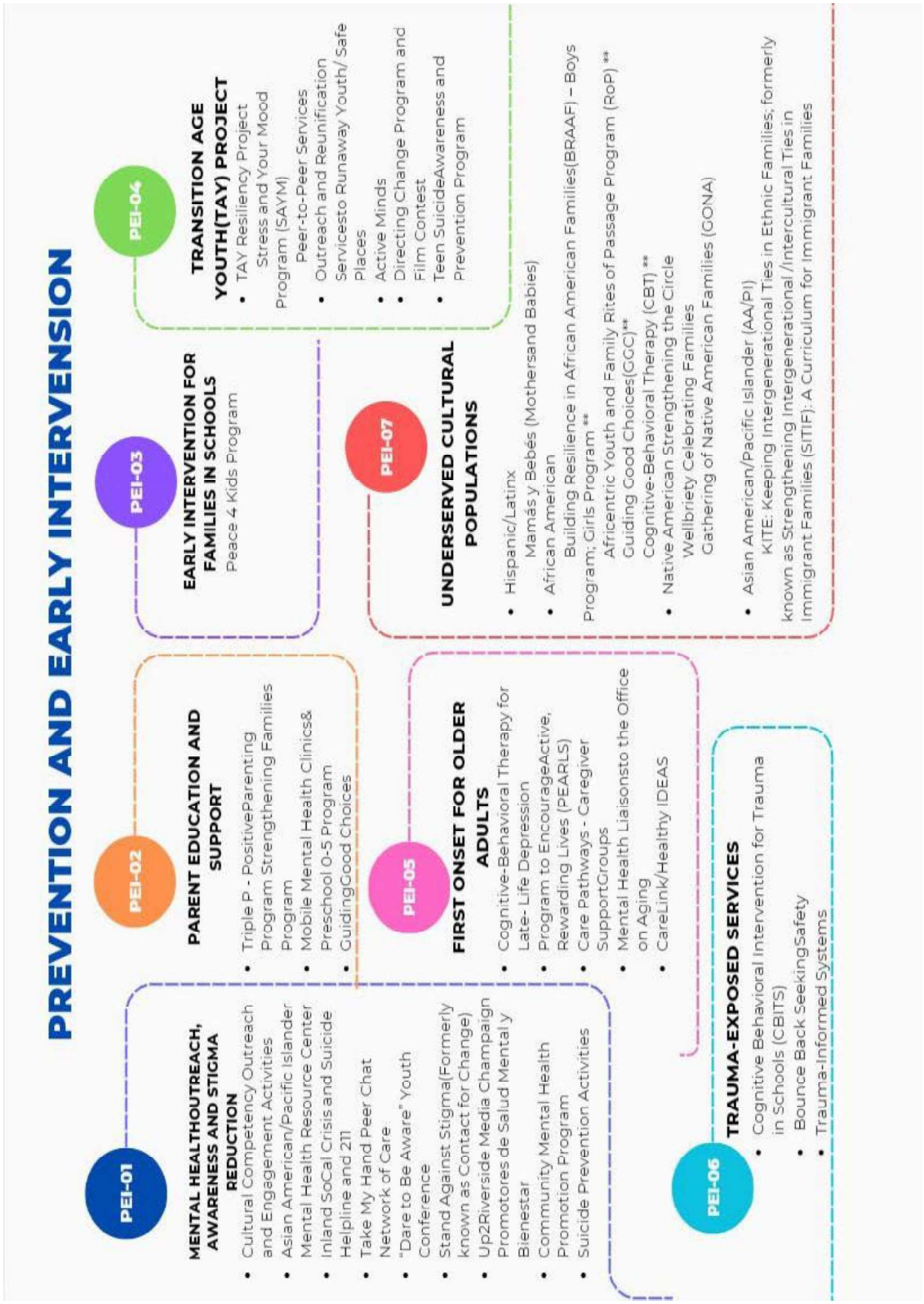
# Prevention and Early Intervention

### MHSA Annual Updates 25/26

PEI

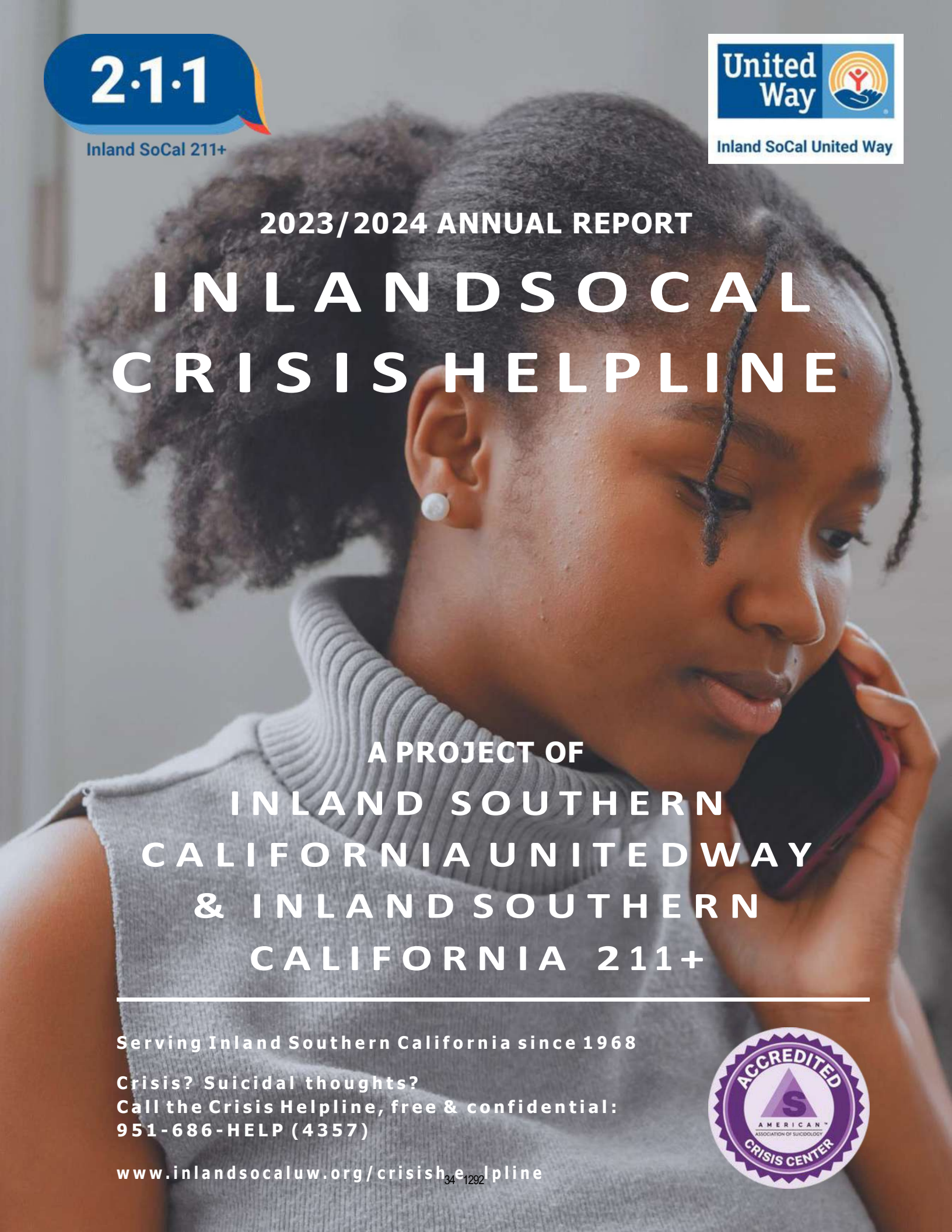
# Prevention and Early Intervention

5




[5] ** denotes programs that will be removed from the PEI plan

# PEI Progress and Outcome Reports



2·1·1 Inland SoCal 211+

United Way Inland SoCal United Way

## 2023/2024 ANNUAL REPORT

# INLANDSOCAL CRISIS HELPLINE

A PROJECT OF

## INLAND SOUTHERN CALIFORNIA UNITEDWAY & INLAND SOUTHERN CALIFORNIA 211+

Serving Inland Southern California since 1968

Crisis? Suicidal thoughts?
Call the Crisis Helpline, free & confidential:
951-686-HELP (4357)

www.inlandsocaluw.org/crisishelpline

ACCREDITED AMERICAN ASSOCIATION OF SUICIDOLOGY CRISIS CENTER

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Inland SoCal United Way

Inland SoCal 211+

# EXECUTIVE SUMMARY

The Inland SoCal Crisis Helpline (951-686-HELP) is a project of Inland SoCal United Way and Inland SoCal United 211+. Services include 24/7 someone to call, routing to somewhere to go (Mental Health Urgent Care) or warm hand-off to someone to come to you (Riverside County Crisis Mobile). The Inland SoCal Crisis Helpline also provides a statistical dashboard, evidence-based training like Mental Health First Aid and social work field placements via six universities.

The goal of this annual report is to increase access to local data and evidence about community mental health trends and to enhance dialogues for suicide prevention regional planning.

To illustrate the types of situations that require support, this report also includes real stories.

**KEY FINDINGS:**

- The number of calls to 686-HELP went up by **128%** from July 2023 (407 Calls) to June 2024 (928 Crisis Calls).
- **Calls for Crisis Mobile services increased by 444.2% within two fiscal quarters** from December 2023 (43 Calls) to June 2024 (234 Calls).
- **Calls for Mental Health Urgent Care increased by 351% within two fiscal quarters** from December 2023 (51 Calls) to June 2024 (230 Calls).
- Overall, we had **53% more calls** this year than last year and 67% more calls compared to two years ago. Most of these new calls came after we started the 24/7 mobile service.
- **Active rescues for imminent risk to life only constituted 0.63% of total calls, even though call volume increased.** This is a decrease from all prior years which demonstrates that the launch of 24/7 crisis mobile services provided a less intrusive intervention in most situations.
- **The number of BIPOC callers in the last 12 months increased by 20% over the previous year** (although there was no proportional increase in crisis callers).
- **Crisis Helpline internships support next generation behavioral health professionals.** 26 social work students having completed a suicide prevention internship in the 2023/2024 school year, 100% of recent program graduates report wanting to continue service in crisis care.

# COMMUNITY CRISIS CARE

The Inland SoCal Crisis Helpline (951-686-HELP) is one of the longest running suicide hotlines in California. Our Crisis Workers answer over 8,000 calls and train over 500 residents a year in courses like Mental Health First Aid. Our service is free, confidential, and can be anonymous. Bilingual counselors are available.

*Serving Inland Southern California since 1968*

## TELEPHONIC EMOTIONAL SUPPORT

24/7 Crisis Counseling with highly trained, compassionate Crisis Workers. We make mental health crisis and suicide prevention easily accessible through locally operated tele-help. 951-686-HELP provides active listening, emotional support, suicide prevention, collaborative problem solving, and a connection to in-person support via the verified 211 database.

## CRISIS CONTINUUM OF CARE

On January 1, 2024, Riverside County launched a new 24/7 Crisis Mobile Unit, accessible through our Inland SoCal Crisis Helpline, 951-686-HELP. The expanded service, provided by our primary funder, the Riverside University Health System, also offers telephonic crisis intervention and connects callers to three 24/7 Mental Health Urgent Care Centers. Aligned with SAMHSA's Crisis Continuum of Care, Inland SoCal United Way ensures individuals in crisis have someone to call, somewhere to go, and someone to come to them around the clock and for free.

## PREVENTION & POSTVENTION

The Inland SoCal Crisis Helpline also trains 500 people a year to help prevent suicide via Mental Health First Aid (8 hours), safeTALK (4 hours), ASIST (16 hours), and QPR (60 minutes). In addition, we partner on postvention services with the Trauma Intervention Team to respond to suicide deaths.

## SOCIAL WORK FIELD PLACEMENTS

Social work internships are an invaluable part of practical training and supervised experience to deliver mental health and social services. Since starting the internship program in 2020, the Inland SoCal Crisis Helpline has trained more than 100 graduate and undergraduate students from 6 universities.

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## What's next?

With 56 years of local crisis care service, the AAS and Inform USA Accredited Inland SoCal Crisis Helpline seeks to expand our reach by joining the 988 network. We also seek to expand our service area to the entire Inland Southern California region.

# CRISIS CONTINUUM OF CARE

*17.81% of calls were referred to Mental Health Urgent Care*

The Inland SoCal Crisis Helpline and the Riverside County (RUHS) Crisis Mobile Unit expanded the continuum of crisis care in 2024. **In this first partnership year, the Crisis Helpline assessed and warm transferred 174 calls to RCCMU for in-person support.**

The Substance Abuse and Mental Health Services Administration (SAMSHA), a Crisis Continuum of Care, consists of three core components: 1) Regional Crisis Call Centers, 2) Local Mobile Crisis Response Teams, and 3) Local Crisis Stabilization Centers. This creates a Continuum of Care, providing community members with Someone to Call, Someone to Come, and Somewhere to Go during a mental health crisis. The model decouples mental health crisis from law enforcement. In Riverside County, the Inland SoCal Crisis Helpline (951-686-HELP) is the front door phone number for community members and helping professionals to request screening and prospective dispatch of the Mobile Crisis Unit or referral to a Mental Health Urgent Care Center.

**Chart 1. Crisis Mobile Referrals by Age 2023-2024**

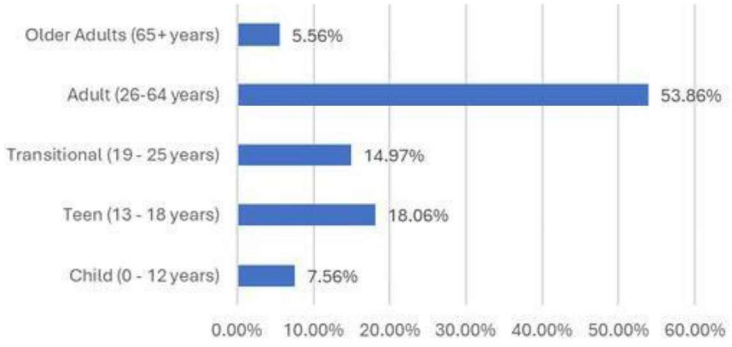
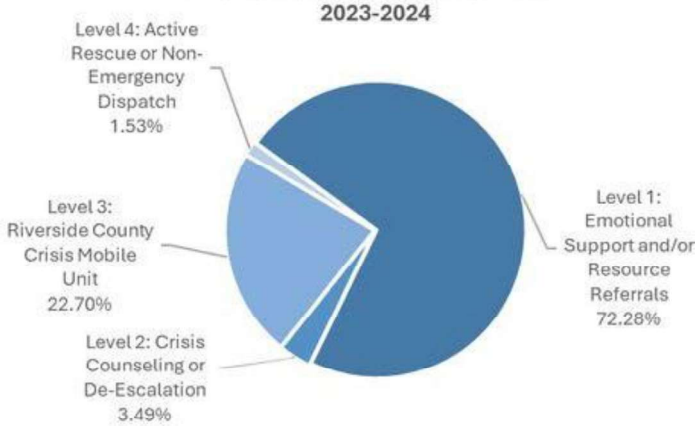



**Chart 2. Crisis Continuum of Care 2023-2024**




## IMPACT

*Topics of Crisis/Importance*

The following are real-life issues of diverse needs that were addressed in the last year that illustrate the type of calls needing in-person crisis support:

- Economic Despair
- Personal Relationship Conflict
- Substance Misuse Disorder
- Isolation/Loneliness
- Elder/Child Care Stress
- Major Life Events
- Grief/Loss
- Chronic Mental Illness
- Physical Illness/Pain
- Work/School Stress

# RAPID REPORTING

## Crisis Helpline Annual Report 2023-2024

As part of the Youth Suicide Rapid Reporting and Response Pilot via the California Department of Public Health and Riverside UHS Public Health, Inland SoCal Crisis Helpline launched a dashboard to share with the public data on:

- Total Calls to 951-686-HELP
- Calls with Suicidal Content
- Active Rescues via 911
- Referrals to Mental Health Urgent Care
- Calls Transferred to Crisis Mobile Unit
- Total Calls to 951-686-HELP by Date

### EMERGENCIES

*Emergencies are about 5% of call volume. These are the most intense, unpredictable calls, ranging from active suicide attempts, child and elder abuse, homicidal intent and other forms of imminent danger.*

- **Active rescues have decreased by 16.13% since the prior year.** In 2023-2024, there were 52 active rescues via 911 dispatch for calls involving imminent or active harm to self or others (2022-2023: 62 active rescues).
- **In the role of caring for vulnerable populations, the Crisis Helpline is a mandated reporter of suspected abuse and neglect.** There were 8 reports of child abuse and 19 reports of elder or dependent abuse.

### DEMOGRAPHICS

*Riverside County is one of the largest counties in the country, the size of Oklahoma. It is also one of the most diverse communities in the country, and our callers reflect this.*

- **Gender Identity**: 59.67% Female (4084); 40.08% Male (2743); 0.25% LGBTQIA+ (17)
- **Race/Ethnicity:** 74.66% BIPOC (772); 25.34% White (Non-Hispanic) (262)
- **Age:** 11.47% Youth 0-17 (265); 13.24% Transition Aged Youth 18-25 (306); 32.93% Adults 26-49 (761); 31.33% Older Adults 50-64 (724); .03% Older Adults 65+ (255)

# ECONOMIC INSECURITY

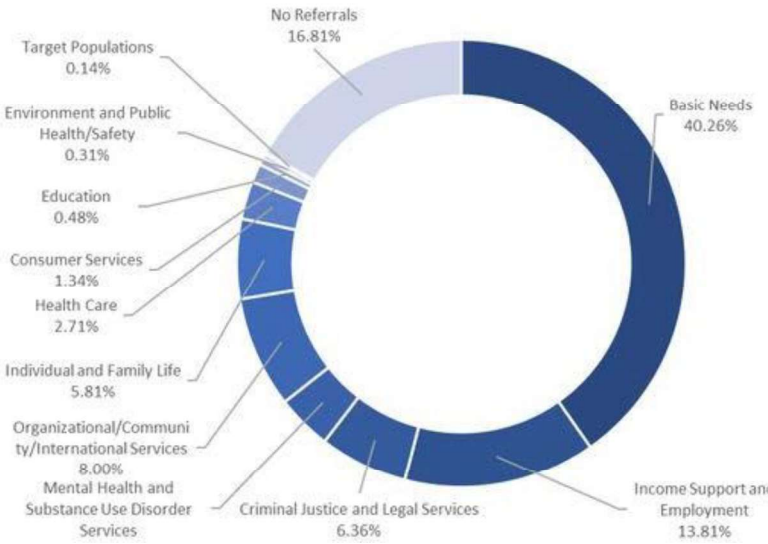
## Crisis Helpline Annual Report 2023-2024

Economic security and mobility are protective factors for mental health. Inland SoCal 211+ Callers frequently discuss stressors associated with meeting basic needs, including needing services for food, housing, clothes, and other essentials. Inland SoCal Crisis Helpline (951-686-HELP), a program of Inland SoCal 211+, provides specialized behavioral health crisis support. Callers to this line are primarily individuals experiencing mental health or substance use crises. For callers requiring additional social services, such as food, housing, or utility assistance, 686-HELP Crisis Counselors transfer them to 211 Referral Specialists for appropriate support. Conversely, 211 Referral Specialists transfer individuals presenting with immediate behavioral health crises to 686-HELP. During the last fiscal year, Riverside County residents placed 48,111 calls to 211 seeking social services. Among these, 40.26% expressed urgent needs related to basic necessities like food, utilities, and housing. The United Ways of California Real Cost Measure finds that 1/3 of residents in Riverside and San Bernardino Counties do not have enough income for daily living needs, like food, housing, utilities, and other essentials.

Despair is a feeling of hopelessness, in this case resulting from an external factor over which callers have very little control—their economic position:

- Older adults express that housing unaffordability and homelessness cause suicidal thoughts.
- Parents express that they cannot make ends meet and provide for their children, causing emotional distress.
- Children and teens feel distraught due to financial stress that puts added pressure on families.
- Unhoused crisis calls show that extreme chronic stress damages mental health and causes depression, anxiety, and emotional distress.

Chart 4. Riverside County 211 Calls by Need Category FY 23-24




### IMPACT

*Topics of Crisis/Importance*

The following are real examples of economic despair issues needs that were addressed in the last year that illustrate the type of calls needing in-person crisis support:

- Housing (Lack of stable housing or lack of shelter or living with unsafe individuals)
- Employment (unemployment, underemployment, or holding multiple jobs)
- Basic Needs (lack of food, utilities, elder care, child care, or medical care)
- Transportation (lack of transportation to work or medical appointments)

# PREVENTION & POSTVENTION

## Crisis Helpline Annual Report 2023-2024

In addition to responding to active crises, the Inland SoCal Crisis & Suicide Helpline provides trainings, courses, and workshops to prepare the general public, schools, businesses, and other providers to identify and respond to mental health needs and suicide signs. **In the 2023-2024 program year, Inland SoCal Crisis Trainers conducted 320 hours of training across 39 days to 29 cohorts.**

*"I couldn't prevent the suicide of my family member many years ago, but I feel blessed to have new tools from this safe TALK workshop. I now know what to do if someone tells me they have suicidal thoughts."*

## TRAINING COURSES:

**Question Persuade Respond (QPR)** is a 90 minute evidence based workshop with three steps anyone can learn to help prevent suicide.

**Applied Suicide Intervention Skills Training (ASIST)** is a two-day interactive workshop and suicide first aid course. Ages 16+. Available in English.

**Mental Health First Aid** is an 8-hour course that teaches the public to help someone with mental health needs. Ages 18+. Available in English.

**Suicide Alertness/safeTALK** is a 4-hour course that helps the public recognize a person with thoughts of suicide and connect life-affirming help. Ages 15+. English and Spanish.

In 2023-2024, we also continued to support postvention services to help individuals heal from suicide loss and other situations. We are proud to partner with the Trauma Intervention Program (TIP) Riverside Chapter. TIP is a dedicated group of everyday people helping everyday people in traumatic crises. Their group of helpful, supportive volunteers is here to serve the needs of anyone when requested by a first responder, hospital personnel, paramedic, or coroner's office to bring emotional first aid to survivors, friends, and family in crisis.

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# FIELD PLACEMENTS

## Crisis Helpline Annual Report 2023-2024

Mental health services are vital to community wellness. But the number of licensed therapists in California declined by 20% from 2016 to 2020 (CalHHS). This strains mental health care already overburdened by increased needs due to the pandemic, inflation, wildfires, gun violence, racism, the housing crisis, and other stressors. In 2020, to support the need for more mental health workers, the Inland SoCal Crisis & Suicide Helpline launched a workforce development effort. The program gives mental health career track students with a fieldwork site and behavioral health work experience while centering the development of their own protective factors to stay in the field.

*Interns and Staff represent Crisis Helpline at the Out of Darkness Suicide Prevention Walk at Fairmont Park, September 2023.*

### Participating Universities:

- California Baptist University
- La Sierra University
- Grand Canyon University
- Chamberlain University
- Western New Mexico University
- University of Louisville

***"I feel like serving at the Inland SoCal Crisis Helpline as a social work intern has prepared me to provide crisis intervention wherever I serve in the future."- Yarrezeth, 2023-2024 Intern; California Baptist University"***

### Preparing the Next Generation:

- More than 100 students have completed the program since launch.
- 26 students completed a behavioral health internship with Crisis Helpline in 2023-2024.
- 24 of the 26 students were Master's of Social Work graduate student interns. The remaining 2 were undergraduate students completing a Bachelor's degree in social work.
- 100% completed over 60 hours of suicide prevention and crisis intervention training and assisted thousands of community members in crisis.
- 100% of program graduates report having a long-term goal to remain in the behavioral health profession, and many report wanting to work long-term in crisis care.

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# ACKNOWLEDGEMENTS

## Crisis Helpline Annual Report 2023-2024

In recognition of their contributions, the Inland SoCal Crisis & Suicide Helpline acknowledges and is grateful for support from all community partners in the 2023-2024 program year.

**With special thanks to:**

**Riverside County Behavioral Health (RUHS)** for their 56 years of funding and partnership support to the Crisis Helpline services in Riverside County.

**Kristin Miller of the Riverside County Crisis Mobile Unit** for developing and launching our joint effort to make mobile crisis accessible to the general public through the Crisis Helpline.

**Riverside County Public Health (RUHS)** for their 2023-2025 grant focused on expanding Crisis Helpline awareness and suicide prevention training in Eastern Riverside County.

**Dr. Charles Lee-Johnson, Froylana Miller and Judy Latham of California Baptist University's Department of Social Work** for our 6th year anniversary of partnership with their department. 75% of the Crisis Helpline's social work interns each year join us from their program. With training and supervision by Crisis Helpline staff, their interns answer roughly half of all calls.

**Prof. Daphne Thomas and Dr. Marni Straine of La Sierra University's Department of Social Work** for supporting our team with additional training and development opportunities.

**Riverside County Suicide Prevention Co-Chairs, Diana Guiterrez (RUHS-BH) and Rebecca Antillon (RUHS-PH**) for their ongoing collaboration and support of regional suicide prevention.

**Magda Stewart of Riverside Trauma Intervention Program** (TIP) for partnering on postvention services to survivors of suicide loss.

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Riverside University HEALTH SYSTEM Behavioral Health

# Stand Against Stigma

Riverside University Health System - Behavioral Health

MHSA Prevention and Early Intervention

Annual Report FY 2023-2024

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# Program Overview and Provider

## Program Overview and Provider*:*

MHSA Prevention and Early Intervention has funded stigma reduction programing focused on specific presentations that are aimed at: (1) reducing stigma regarding mental illness, and (2) increasing community awareness within target populations regarding mental health information and resources. “Stand Against Stigma” is an anti-stigma program based on leading researchers’ previous studies about the importance of increasing community awareness about mental health information and resources, that suggests five principles that effectively decrease the consequences of public stigma, referred to as TLC3 (Targeted, Local, Credible, Continuous, Contact). This program is provided by RUHS-Behavioral Health Prevention and Early Intervention Peer Support Specialists known as PEI Peers. They provide services throughout the three regions of Riverside County: Desert, Mid-County, and Western.

Peer Support Specialists promote the consumer perspective in all their presentations. Stand Against Stigma is designed to provide anti-stigma presentations to individuals and organizations by specifically outreaching and collaborating with schools, businesses, community organizations, and faith-based organizations throughout the county to bring presentations to as many people as possible.

“Stand Against Stigma” presentations are utilized to educate and outreach to target audiences to share the unique stories of those with mental illness with the aim of reducing stigmatizing attitudes. Presentations are evidence-supported and structured to discuss mental health through presenters sharing their lived experience with mental health challenges and including an ‘on-the-way-up’ message to discuss strengths and recovery because of services, supports, and/or treatment. Presentations are aimed at reaching the following target audiences: community members, employers, landlords/housing officials, health care providers, other government-related entities, faith -based communities, and media.

# Executive Summary: Key Findings

During the fiscal year 2023-2024, there were a total of 14 “Stand Against Stigma” presentations held by RUHS-Behavioral Health PEI Peers in the Desert (n=8), Mid-County (n=1), and Western (n=5) regions, for a total service of 14 hours. The majority of events targeted the general community.

- There were a total of 248 people who attended “Stand Against Stigma” presentations. The presentations were held either in-person or virtually via Zoom (n=14), the total number includes attendees from outside Riverside County regions. Due to the Stand Against Stigma program being provided to people who reside, work, or study in Riverside County, one (1) individuals who resided outside of Riverside County was excluded for analysis purposes. Additionally, one (1) individual who did not provide information regarding their residence was excluded as well. Moreover, 139 attendees did not complete the demographic and pre/post questionnaires. This resulted in only 109 attendees who were included in the analysis for this report.
- Most attendees resided in the Desert region (n=71, 65.1%).
- The attendees’ ages ranged from 19 to 68 years old, with an average age of 40 years old.
- The most frequently reported race/ethnicity for all regions was Hispanic/Latinx (n=65, 59.6%).
- The majority of attendees were female (n=72, 66.1%).
- Post-test results revealed a statistically significant increase in participants’ affirming attitudes regarding recovery from mental health conditions, as well as a greater willingness to seek mental health services and support if they experience psychological challenges. Paired samples T-test showed statistically significant results for Stigmatizing Attitudes and Care-Seeking Attitudes scales ($p<=0.001$).
- Speaker’s Bureau attendees reported strong satisfaction with the enthusiasm and knowledge of the Speaker’s Bureau presenters, and a high likelihood to recommend the program to others.

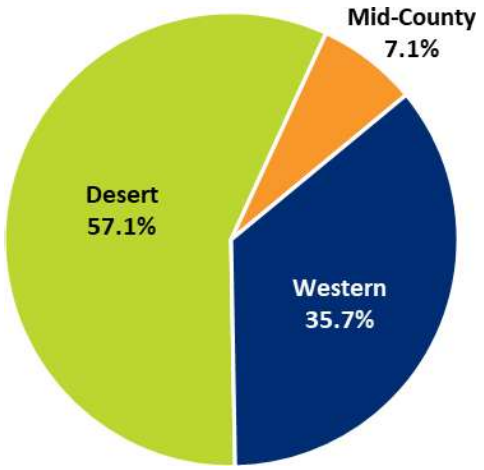
# Event Statistics

RUHS-Behavioral Health PEI Peers are expected to hold 40 “Stand Against Stigma” presentations per region each year. During FY 2023-2024, a total of 14 presentations were held throughout the County and no region met expectations.

| RUHS-BH PEI Peers<br>FY 2023-2024 Speaker’s Bureau Events Countywide | | | |
|---|---|---|---|
| **Presentation Format** | **Contract Expectation** | **Current Total** | **Percent Completion** |
| **Speaker’s Bureau** | **120** | **14** | **11.7%** |

## Event Statistics by Region

Out of the 14 total "Stand Against Stigma" presentations conducted by RUHS-BH PEI Peers, the majority took place in the Desert region (n=8), followed by the Western region (n=5), and the Mid-County region (n=1).




The presentations were evenly split between virtual and in-person formats, with 7 of each. The PEI Peers collaborated with a variety of community venues, including libraries, family engagement centers, colleges, social services organizations, and other community locations.

## Event Duration by Region

| Region | Total Time |
|---|---|
| **Countywide** | **14 Hours** |
| **Desert** | **8 (57.1%)** |
| **Mid-County** | **1 Hour (7.1%)** |
| **Western** | **5 Hours (35.7%)** |

The total presentation time that was spent on Speaker’s Bureau events across all regions was 14 hours, with the Desert, Western, and Mid-County regions making up 57.1%, 35.7%, and 7.1% of the total time, respectively. The average time was 1 hour for presentations. Most of the presentations were conducted only in English (n=12, 85.7%), while an additional one presentation were conducted in American Sign Language (7.1%), and one more presentations were conducted in Spanish (7.1%).

# Event Statistics cont.

## City/Zip Code Locations

| Region | City and Zip Code | Countywide |
|---|---|---|
| Desert | | **8 (57.1%)** |
| | Indio, Palm Desert, Thermal | 5 (62.5%) |
| | Virtual | 3 (37.5%) |
| Mid-County | | **1 (7.1%)** |
| | Virtual | 1 (100%) |
| Western | | **5 (35.7%)** |
| | Riverside, 92507 | 2 (40.0%) |
| | Virtual | 3 (60.0%) |

In FY 2023-2024, a total of 14 “Stand Against Stigma” presentations were delivered by providers, either virtually via Zoom or in-person. Of the seven in-person presentations, five took place in the Desert region and two in the Western region, with one event occurring in the Mid-County region.

## Target Population

| Target Population | Countywide (n=14) |
|---|---|
| **Community** | 12 (85.7%) |
| **Peers** | 1 (7.1%) |
| **Other** | 1 (7.1%) |

Speaker’s Bureau presentations were intended to target particular populations in non-traditional settings. The largest target population reached by the program was to the “Community” (n=12, 85.7%), followed by “Peers” (n=1, 7.1%) and “Other” (n=1, 7.1%). The community was reached through libraries, community organizations, and colleges.

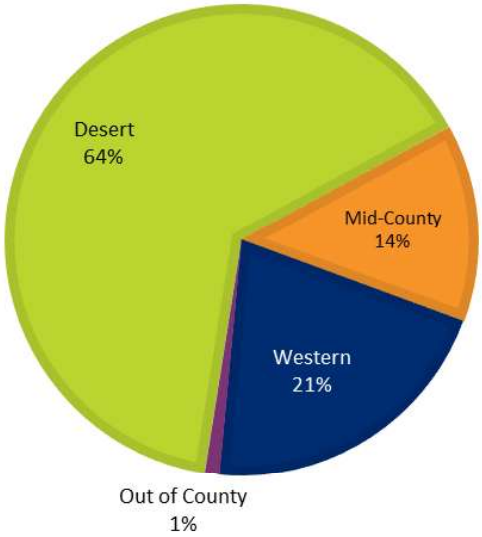
# Participant Demographics

## Attendance

A total of 248 individuals participated in the 14 “Stand Against Stigma” presentations during the fiscal year 2023-2024. Attendees were asked to complete demographic forms and pre/post surveys at each event. In total, 111 demographic forms and surveys were submitted, including responses from non-Riverside County residents, employees, or students (n=1) and individuals with unknown residency (n=1). Since the program is exclusively available to Riverside County residents, employees, and students, the analysis was based on 109 valid responses. Countywide analysis revealed a small percentage of attendees who identified as LGBTQ+ (n=14, 12.8%) or as having a disability (n=9, 8.3%), with no attendees identifying as veterans.

## Residence by Region

Of the 109 total attendees who live, work, or study within Riverside County, most were from the Desert region (n=71, 64.5%), followed by the Western (n=23, 20.9%), and Mid-County regions (n=15, 13.6%) of Riverside County with the remaining living outside of the county (n=1, 1.0%). The figure below shows the total attendance by region of residence.




## Language

| Language | Countywide (n=109) |
|---|---|
| **English** | 97 (89.0%) |
| **Spanish** | 9 (8.3%) |
| **Both** | 2 (1.8%) |
| **Not Reported** | 1 (1.0%) |

## Age

| Age Range | Countywide (n=109) |
|---|---|
| **18 to 29 years old** | 16 (14.7%) |
| **30 to 39 years old** | 34 (31.2%) |
| **40 to 49 years old** | 38 (34.9%) |
| **50 to 59 years old** | 16 (14.7%) |
| **60 to 69 years old** | 3 (2.8) |
| **70 years or older** | 0 (0%) |
| **Not Reported** | 2 (1.8%) |

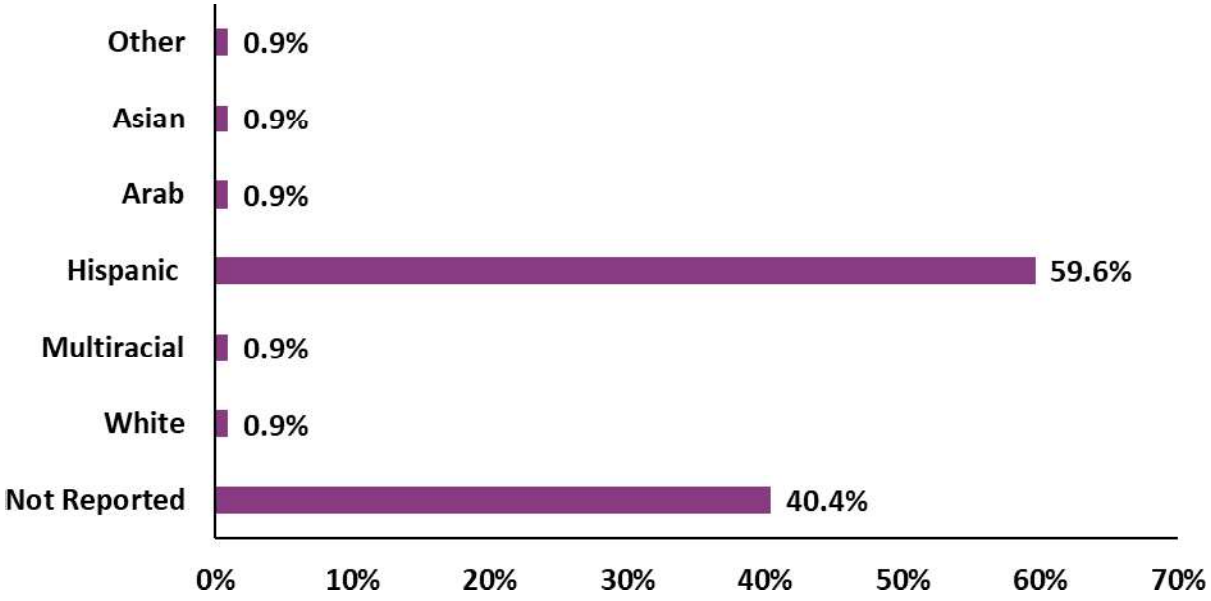
The table above presents the distribution of reported ages. Among the 109 attendees residing, working, or studying within Riverside County, the average age was 40 years, the median age was also 40 years, and the most frequently reported age was 39 years.

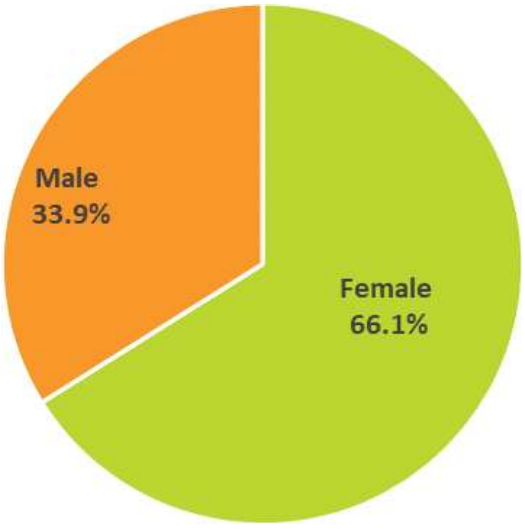
Among the 109 attendees residing, working, or studying in Riverside County, the majority (n=97, 89.0%) indicated that English was their preferred language, while 8.3% (n=9) preferred Spanish. One attendee selected both English and Spanish as their preferred languages, and another declined to respond.

# Participant Demographics cont.

## Race/Ethnicity

Of the 109 total attendees who live, work, or study within Riverside County, the majority of attendees identified as Hispanic or Latino/Latina (n=65, 59.6%). A small fraction of attendees identified as White (n=1, 1.0%), Asian American (n=1, 1.0%) and Multiracial (n=1, 1.0%). The rest of the attendees declined to report (n=44, 40.4%)




## Gender

The majority of attendees identified as female (n=72, 66.1%), followed by male (n=37, 33.9%).

## "Stand Against Stigma" Pre/Post Test Questionnaire

Pre-tests and post-tests were administered immediately before and after each "Stand Against Stigma" presentations in order to assess its impact on the attendees. The pre and post questionnaires were designed using a Likert Scale of 1 to 9, where 1 represents "Strongly Disagree" and 9 represents "Strongly Agree". There are a total of 15 questions in the pre and post questionnaires, in which four stigma sections were measured:

- 5 Questions on Stigmatizing Attitudes (AQ-5)
- 3 Questions on Recovery Attitudes (RS-3)
- 3 Questions on Empowerment Attitudes (ES-3)
- 4 Questions Care-Seeking Attitudes (CS-4)

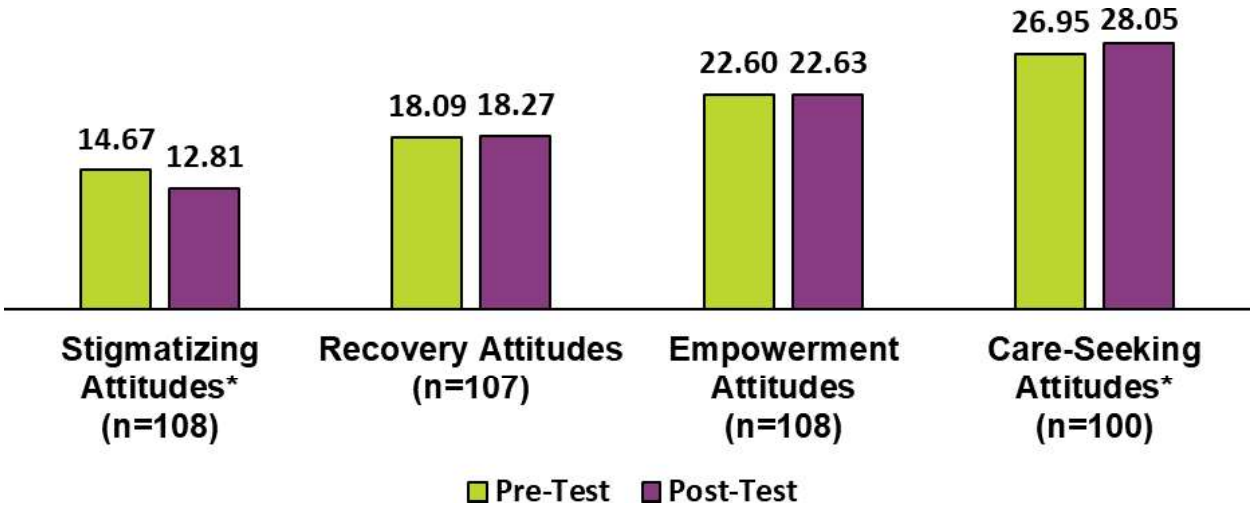
| Measures of Stigma | Questionnaire | Rating Scale |
|---|---|---|
| Stigma Change (AQ-5) | Five-item Attribution Questionnaire (AQ-5) assessing participants' cognitive, affective, and behavioral reactions to people with mental illnesses.<br>*Example: "I think that most people with mental illness are to blame for their problems."* | Score range: 5-45<br>1 = 'Strongly Disagree'<br>9 = 'Strongly Agree' |
| Recovery Attitudes (RS-3) | Three-item Recovery Scale (RS-3) assessing participants' attitudes toward people with mental health conditions' capabilities to overcome psychological challenges.<br>*Example: "People with mental illness are hopeful about their future."* | Score range: 3-27<br>1 = 'Strongly Disagree'<br>9 = 'Strongly Agree' |
| Empowerment Attitudes (ES-3) | Three-item Empowerment Scale (ES-3) assessing participants' attitudes about people with mental illness relative to people without.<br>*Example: "I see people with mental illness as capable people."* | Score range: 3-27<br>1 = 'Strongly Disagree'<br>9 = 'Strongly Agree' |
| Care-Seeking Attitudes (CS-4) | Four-item Care Seeking Questionnaire (CS-4) assessing participants' willingness to seek out mental health services if they were experiencing impairing anxiety and/or depression.<br>*Example: "I would speak to a counselor if I were significantly anxious or depressed."* | Score range: 6-54<br>1 = 'Strongly Disagree'<br>9 = 'Strongly Agree' |

A total of 109 attendees participated in a "Stand Against Stigma" presentation and completed pre- and post-test outcome measures. However, one attendee did not complete all items in the Stigmatizing Attitudes scale (n=108), two attendees did not complete all questions related to Recovery Attitudes (n=107), one attendee did not fully complete the Empowerment Attitudes scale (n=108), and nine attendees did not complete all items on the Care-Seeking Attitudes scale (n=100).

Scores for all items within each of the four questionnaire sections were summed, with pre/post-test comparisons based on the cumulative scores. Higher cumulative scores for the AQ-5 represent greater stigmatizing attitudes and higher cumulative scores on the RS-3, ES-3, and CS-4 represent more positive attitudes toward the described constructs.

# "Stand Against Stigma" Average Scores: Pre-Tests vs. Post-Tests

In order to measure the effectiveness of the presentations, ideally there would be a decrease in the average scores of the Stigmatizing Attitudes scale from pre- to post-measures and an increase in the average scores of the Recovery Attitudes, Empowerment Attitudes, and Care-Seeking Attitudes from pre- to post-measures. Overall, the average scores across all scales showed improvements from pre -tests to post-tests. Further analysis using paired samples t-tests shows the improvements were statistically significant (p<=.001) for two scales as shown on graph and table below.




Note: Significance levels * = Numbers indicate statistically significant (p<=.001) change from Pre to Post

| Measured Scales | Difference in Average Scores | *t* | df | p |
|---|---|---|---|---|
| Stigmatizing Attitudes (AQ-5) | 1.86 | 4.200 | 105 | .000 |
| Recovery Attitudes (RS-3) | -0.18 | -0.406 | 105 | .685 |
| Empowerment Attitudes (ES-3) | -0.03 | -0.080 | 105 | .936 |
| Care-Seeking Attitudes (CS-4) | -1.10 | -2.699 | 99 | .008 |

When comparing the pre- and post-test results across the scales, the Care-Seeking Attitudes scale demonstrated the most significant increase, with an average score change of 1.10 points, followed by a 0.18-point change in the Recovery Attitudes scale. However, the small increase in Recovery Attitudes was not statistically significant. Additionally, the minimal change in scores on the Empowerment Attitudes scale may be attributed to the relatively high baseline scores of attendees (average of 22.60 points, with a range of 3-27), and this change was also not statistically significant.

Overall, statistically significant improvements were observed in both the Stigmatizing Attitudes and Care-Seeking Attitudes scales. These findings suggest that the "Stand Against Stigma" presentations were effective in positively shifting attendees' perceptions of individuals with mental health conditions, increasing their belief in recovery and empowerment, and enhancing the likelihood of attendees seeking help when facing anxiety and/or depression.

# Satisfaction Surveys

Additional satisfaction questions were included at the end of the "Stand Against Stigma" post-test questionnaire. Using a scale of 1-9, with 1 representing the poorest satisfaction and 9 representing the greatest positive satisfaction, participants were asked to rate the presenters' level of enthusiasm and knowledge (n=109), and their likelihood to recommend others to participate in a similar "Stand Against Stigma" presentation (n=109). Their responses are summarized below:

- With an average score of 8.25, 72.5% of attendees strongly agreed that the presenters were enthusiastic and knowledgeable when sharing the information
- With an average score of 8.17, 70.6% of attendees strongly agreed that they would recommend others to participate in similar activities

The table below shows the percentages of attendees' responses to each satisfaction survey question. On average, all participants who completed the satisfaction questions reported positive feedback (over 87.6% of attendees chose "6" or higher). Additionally, their comments about the events are shown below and continue on the next page.

| | | 1=Strongly Disagree | | | | | | | | 9=Strongly Agree | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Countywide (n=103)** | **Average** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **No Response** |
| 1. The presenters were enthusiastic and knowledgeable when sharing the information. | 8.25 | 3.7% | - | - | 0.9% | 4.6% | 1.8% | 1.8% | 11.9% | 72.5% | 2.8% |
| 2. I would recommend an activity like this to my friends, family members, and colleagues. | 8.17 | 3.7% | - | - | 0.9% | 6.4% | 0.9% | 3.7% | 11.9% | 70.6% | 1.8% |

# Comments

## Additional Comments

- I love that the presenters shared true life stories. It was a heartfelt presentation.
- Thank you for sharing your life experience. I believe we are capable of things. Most people need the support to know that they can be successful .
- Thank you for sharing. You are so brave and strong.
- Great job ! Thank you for sharing your stories. They were powerful and can help so many to learn and feel less alone.
- Your honesty and vulnerability are appreciated. Thank you for your time.
- Thank you! This was wonderful to see and hear that there are people fighting the good fight.
- Brave speakers !
- Thank you for sharing.
- Thank you to [facilitator] and [facilitator] for sharing your stories. Thank you for still being here, and congrats on the work you have done so far. I hope the best for the work ahead.
- Presenters were very brave.
- Very touchful stories.
- Each of their stories was very touching and overall highly recommended.
- Life is a miracle if we can experience it.
- Able to change the cycle, learn from it and grow. Be the best person, sibling, parent, wife.
- The experiences with life were very valuable.
- I would love to see PowerPoint from families.
- Thank you for sharing your stories.

Riverside University HEALTH SYSTEM Behavioral Health

# MHSA Prevention and Early Intervention (PEI)

## Community Mental Health Promotion Program

## FY 2023-24 Annual Report

## Introduction

The ethnically and culturally specific Community Mental Health Promotion Program (CMHPP) trains lay workers in the community (promoters) to outreach to their communities, bring awareness to mental health topics, reduce stigma and provide resources and/or referrals to prevention and early intervention services.

The selected promoters go through a 40-hour training in which they are educated on various mental health topics, given a list of culturally competent local resources and are empowered to create a plan of action as a group to address the unique mental health needs of their community. They provide services in non-stigmatizing community locations such as local churches, community centers, schools and other community locations. The promoters reach out to the Desert, Mid-County, and Western regions of Riverside County, and are especially focused on neighborhoods and communities identified by the MHSA Prevention and Early Intervention (PEI) planning committee as areas of high need. Outreach and education is provided to a range of age groups from middle/high school students, transitional age youth (TAY), adults, and older adults.

## Contracted Partner Agencies

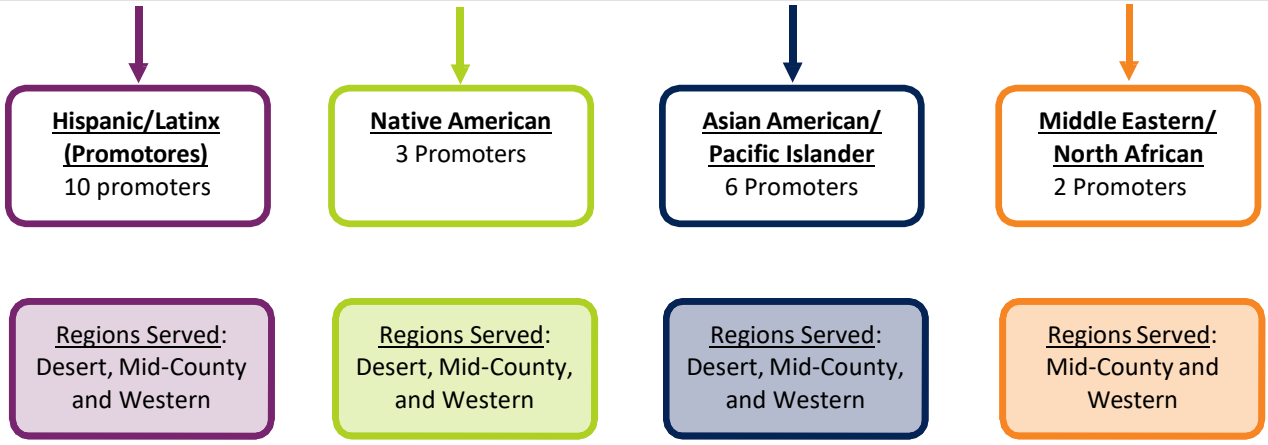
MHSA PEI formed partnerships and contracted with key community agencies. The agencies were responsible for selecting culturally competent promoters who have an understanding of the values, beliefs and language of the community, ensuring that all staffing needs were met and ensuring that the promoters received training as required by MHSA-PEI. They were responsible for program implementation and documentation.

| | |
|---|---|
| **Promotores Latinx/Latino** | MHSA-PEI partnered with Visión y Compromiso, who's committed to community well being by supporting Promotores and Community Health Workers. Visión y Compromiso also have a vision towards a healthy and dignified life. |
| **Native American** RSBCIHI | MHSA-PEI partnered with Riverside/San Bernardino County Indian Health Inc. The organization advocates on behalf of American Indians through the delivery of quality health care services, which honor spiritual and cultural values. |
| **Asian American/Pacific Islander** Asian Pacific Counseling & Treatment Centers is a division of ssg Special Service for Groups | MHSA-PEI partnered with Asian Pacific Counseling and Treatment Centers, a division of Special Service for Groups, Inc. (SSG), specializing in culturally sensitive approaches to address the social and psychological needs of Asian and Pacific Islander communities. |
| **Middle Eastern/North African** SAHABA INITIATIVE Sahaba Initiative nurturing healthy families | MHSA-PEI partnered with Sahaba Initiative who outlines a vision for the Middle Eastern/North African (MENA) communities where mental health is valued and acknowledged with an emphasis on the importance of mental health education and ensuring everyone has access to necessary resources. |

Other contracted agencies have provided Outreach in the past to the Black African American community and LGBTQI community, these contractors were unable to continue so this report includes the current contracts.

## Staffing By Program and Region

Overall in FY 2023-24, **21** promoters provided outreach and presentations across the CMHP programs in the Desert, Mid-County, and Western regions of Riverside County.




## Promoter Training Requirements

As mentioned in the introduction, per contract guidelines, all new promoters are required to complete a 40-hour training which includes topics of safety, community outreach, PEI and community resources, the role of a promoter, mental health topics review, promoter presentations review and data collection. Upon completion of the trainings, program directors complete and submit a performance review of the promoter including strengths and areas of improvement. The promoters also complete an evaluation scoring on a scale of 1-5, if the trainings were effective and helpful in their development as a promoter and if they were confident in their ability to provide community resources and answer questions on mental health issues in a culturally competent way.

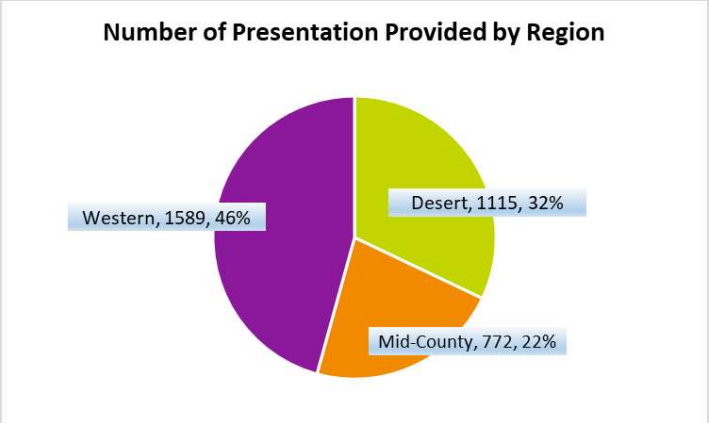
## *Promotores Hispanic/Latinx CMHPP*

### Mental Health Presentations: Service Delivery and Attendance

From July 1st, 2023 to June 30, 2024 promoters for the Promotores Hispanic/Latinx CMHP program provided a total of **3,476** 1-hour mental health presentations across the Desert, Western and Mid-County regions of Riverside County.

A majority of presentations were provided in the Western region of Riverside County **(46%).** Presentations were available in Spanish and English.

Most presentations were in-person (96%), while presentations were also provided virtually (4%). In-person presentations included residential homes or at public locations such as churches, clinics, community centers, libraries, parks, schools, and shopping centers.



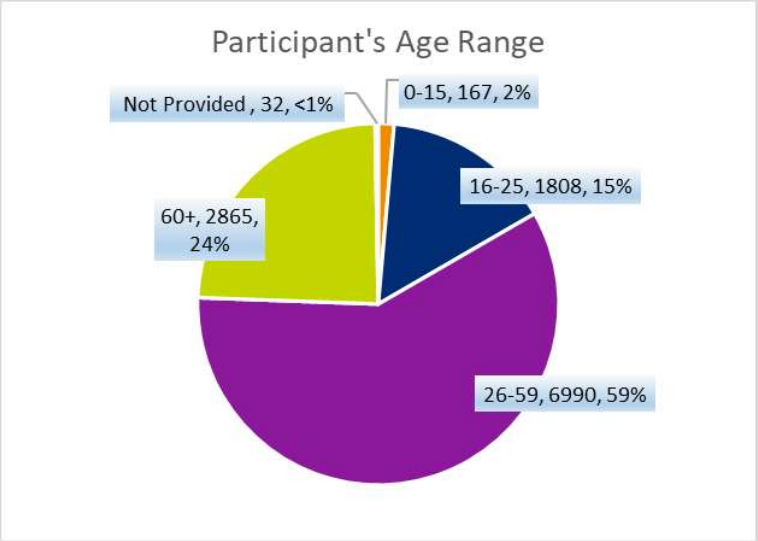

Participants were welcomed to attend more than one presentation. A total of **11,862** people were recorded as attending, which includes those who attended multiple times. Among them, **9,658** reported that attending one of the nine presentation topics was their first time, while **1,879** indicated that they had attended more than one topic, while **325** participants did not response.

Half of the presentations **(54%)** provided by Promotores CMHPP were on Mental Health, Anxiety, and Depression. The remainder of topics **(46%)** discussed were Trauma, Effects of Drugs and Alcohol, Bipolar Disorder, Suicide Prevention, Grief & Loss and Schizophrenia, collectively.

| Topic | n (%) |
|---|---|
| **Anxiety** | **577 (16.6%)** |
| Bipolar Disorder | 311 (8.9%) |
| **Depression** | **581 (16.7%)** |
| Effects of Drugs and Alcohol | 215 (6.2%) |
| Grief and Loss | 159 (4.6%) |
| **Mental Health** | **735 (21.1%)** |
| Schizophrenia | 301 (8.7%) |
| Suicide Prevention | 215 (6.2%) |
| Trauma | 382 (11.0%) |

## Mental Health Presentations: Demographics

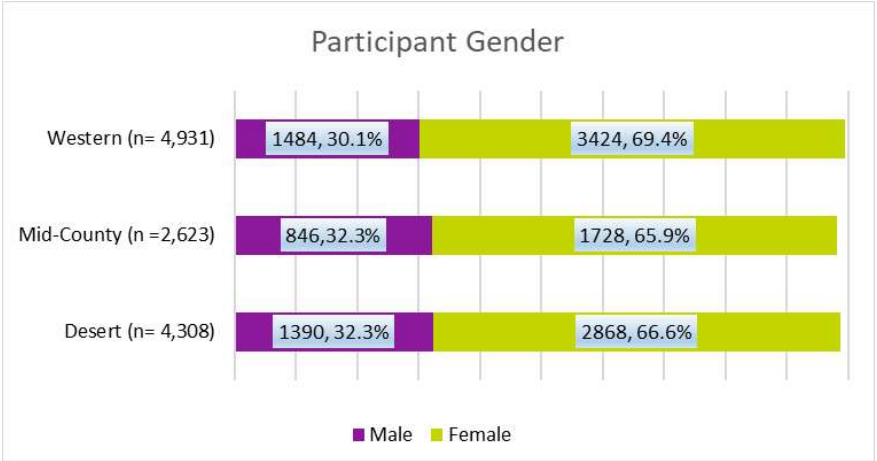
This section highlights the basic demographics of participants provided for FY 2023-24. All data is based on the total number of participants who have attended presentations, including duplicated counts since participants can attend more than one presentation. The graphs below display totals for those participants that provided a response in the presentation sign-in demographic form.




59% of the participants who attended the presentations reported being adults aged 26 to 59 years old. 15% were youth aged 16 to 25, and 24% were 60 and older, while 2% were 15 years old or younger.

Most participants indicated Spanish as their primary language (85%), 5% selected being fluent in both English and Spanish and 9% of participants spoke only English, while <1% did not provide a response.

Regardless of region, the proportion of females reached was greater than the proportion of males. This occurrence could be by chance or influenced by stigma. Hispanic/Latinx male individuals may be less inclined to talk publicly about challenges at home compared to the female member(s) of the household. Overall (not shown in this graph), across all regions, 115 individuals did not self– identify, 6 participants identified as trans, and 1 participant identified as non-binary. Additionally, a very small percentage of participants identified as Lesbian, Gay, or Bisexual (n=37).

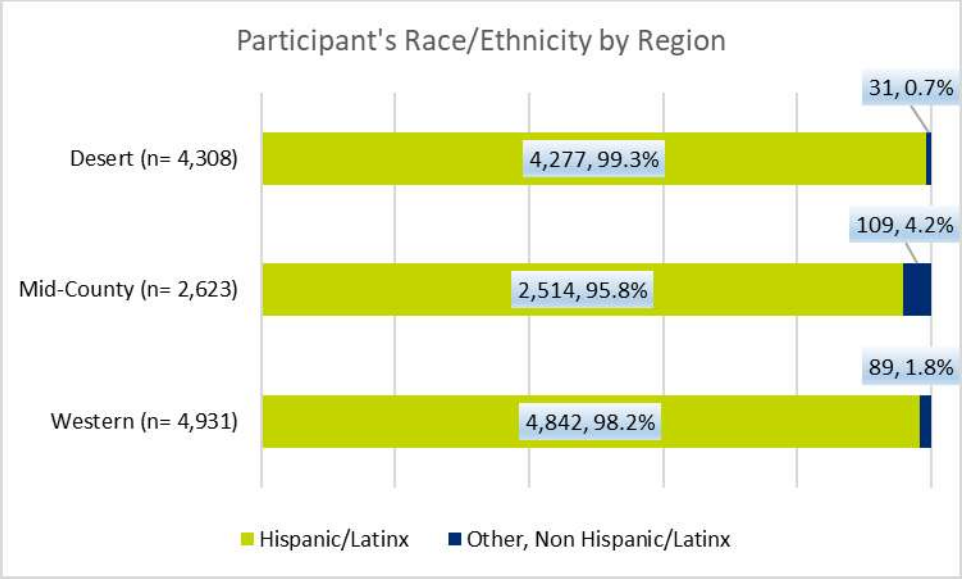



**This data does not include individuals that have self-identified as non-binary, trans, or those who have not provided a gender identity, due to the small number breakdowns. Please refer to text for additional information. Note that totals do not add to 100%.*

## Mental Health Presentations: Demographics (cont.)

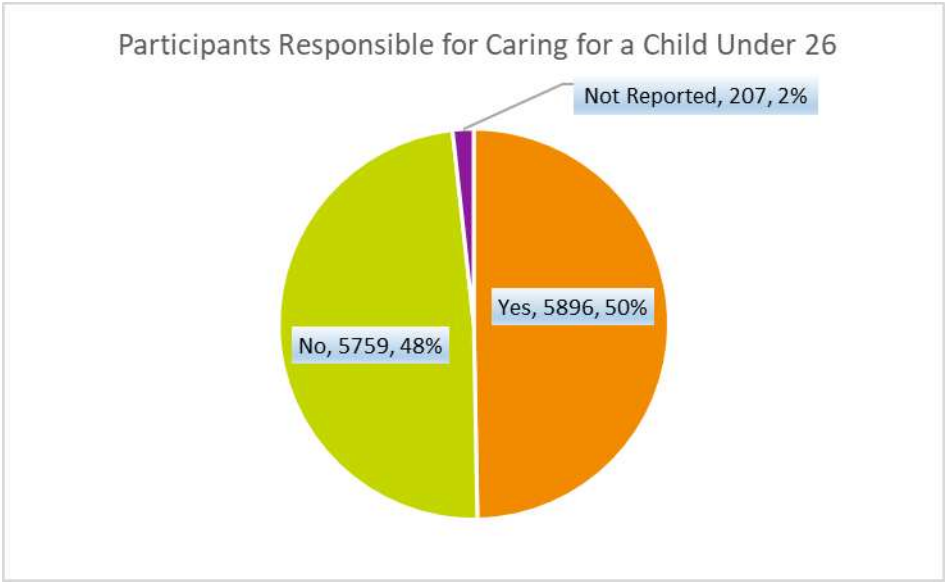
In the Desert, Mid-County, and Western regions, participants in the Promotores CMHP program identified as Hispanic/Latinx (**n=11,633**). Across all regions, 84 self-identified as Caucasian, 23 as Black/African American, 7 as Asian/Pacific Islander, 3 as Native/Indigenous, 48 as Other/Non-Specific, and 48 chose not to self-identify.

While the CMHP program focused on Hispanic/Latinx individuals, it welcomed anyone who felt they would benefit. The graphs below display totals for participants who provided a response on the presentation sign-in demographic form.




**Individuals that did not self-identify as Hispanic/Latinx were categorized as Other, Non Hispanic/Latinx. Please refer to text for additional information regarding racial breakdowns.*

A total of **11,862** responses were submitted regarding caring for a child under 26 years old. Approximately 1 in 2 participants reported having a child under 26. The graph below provides a detailed breakdown of responses across all regions.



## *Promotores Hispanic/Latinx CMHPP*

### Mental Health Presentations: Satisfaction and Feedback

After the presentation, participants were encouraged to complete a satisfaction survey which asked about their satisfaction with the promoter, class content, and their confidence in talking about and seeking help for their mental health. They were asked on a scale of 1-5 (1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree) about how much they agreed with the statements in the survey.

A randomized sample of 500 participants from the 8,527 who completed the satisfaction survey was used to evaluate satisfaction. Surveys from individuals who attended multiple presentations were included, as their experiences may have varied between sessions.

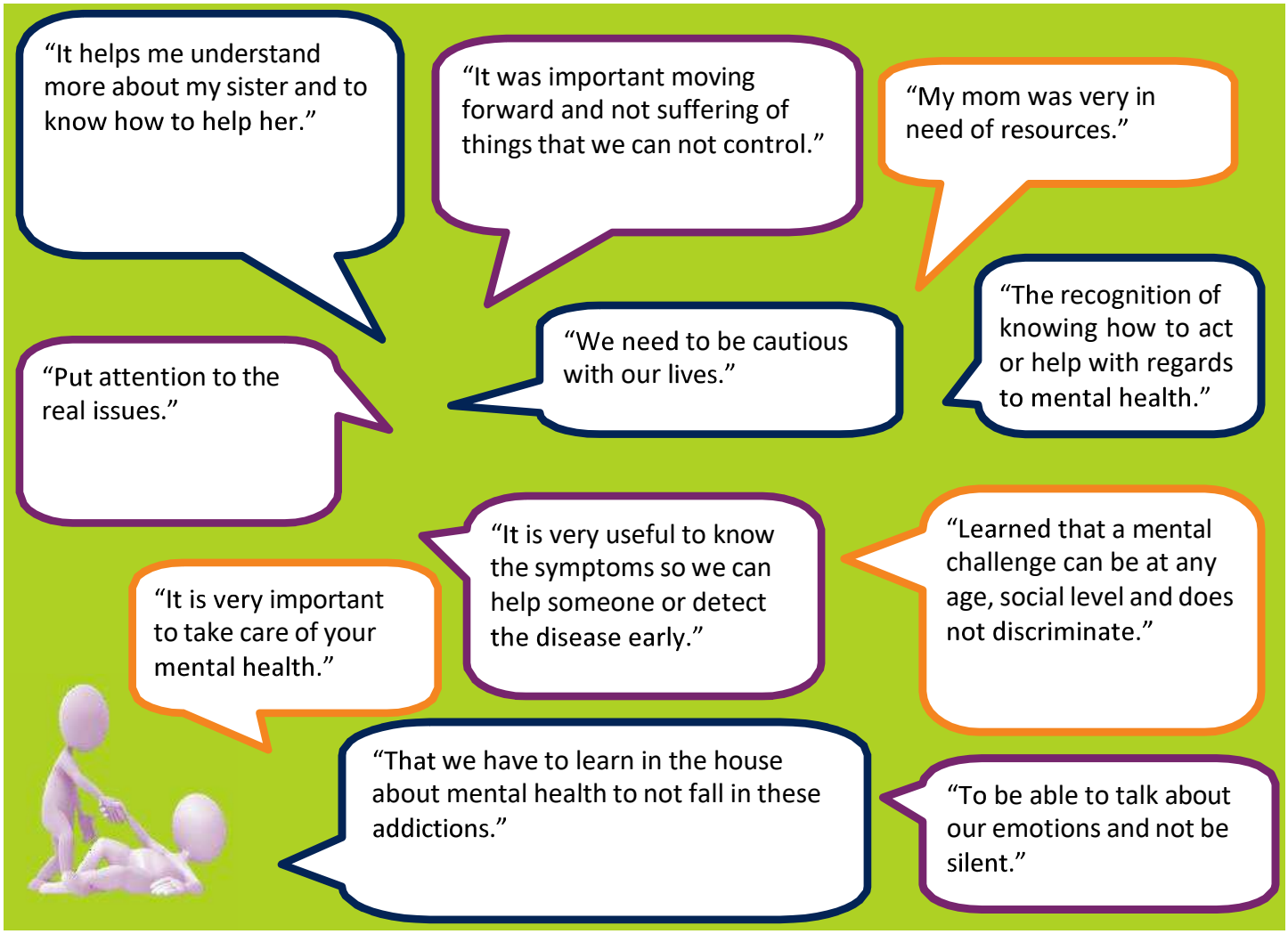
As shown below, a majority of participants strongly agreed with all statements in the survey, indicating they felt confident in seeking help and finding resources, and that they could share the information with family and friends, that they got a better understanding of mental health issues, and that they had a great experience with the promoter.

| Questions (n= 500) | Avg Score | 1 | 2 | 3 | 4 | 5 | No resp. |
|---|---|---|---|---|---|---|---|
| The information presented was easy to understand | **4.93** | – | 1 (0.2%) | 4 (0.8%) | 26 (5.2%) | **467 (93.4%)** | 2 (0.4%) |
| The presenter understands the needs of my community | **4.93** | – | 1 (0.2%) | 4 (0.8%) | 26 (5.2%) | **467 (93.4%)** | 2 (0.4%) |
| I would recommend to my friends and family members that they attend a presentation like this in the future | **4.92** | – | 1 (0.2%) | 5 (1.0%) | 29 (5.8%) | **461 (92.2%)** | 4 (0.8%) |
| The material in this presentation gave me a better understanding of the early signs of mental health issues within my culture | **4.92** | – | 1 (0.2%) | 4 (0.8%) | 27 (5.4%) | **466 (93.2%)** | 2 (0.4%) |
| **As a result of this presentation** | | | | | | | |
| I feel I am better able to talk about this topic with my family and friends | **4.85** | – | 1 (0.2%) | 9 (1.8%) | 54 (10.8%) | **433 (86.6%)** | 3 (0.6%) |
| I know mental illness can me managed and treated | **4.87** | – | 1 (0.2%) | 7 (1.4%) | 49 (9.8%) | **440 (88.0%)** | 3 (0.6%) |
| I feel comfortable seeking help for a family member, friend, or myself | **4.87** | – | 2 (0.4%) | 6 (1.2%) | 48 (9.6%) | **442 (88.4%)** | 2 (0.4%) |
| I know where to seek resources for a family member, friend, or myself | **4.90** | 1 (0.2%) | 1 (0.2%) | 4 (0.8%) | 37 (7.4%) | **455 (91.0%)** | 2 (0.4%) |

***Promotores Hispanic/Latinx CMHPP***

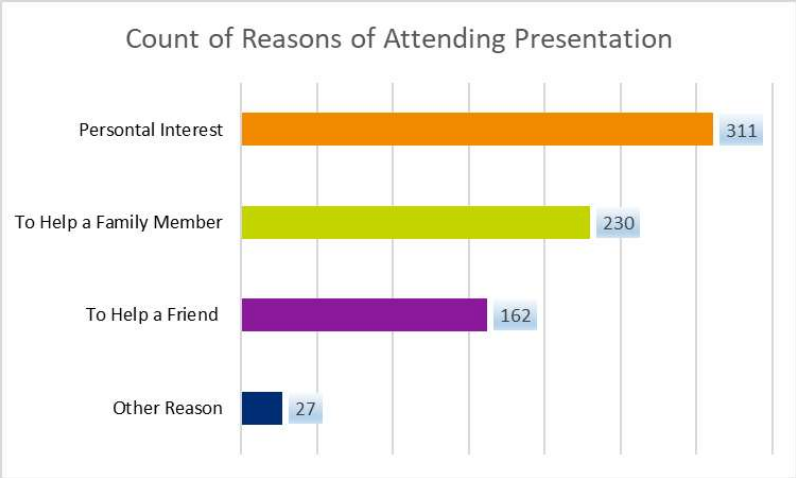
## Mental Health Presentations: Comments

The participants' comments on the satisfaction survey also highlight how well CMHPP was in the community. Below are some of the comments made by participants when asked what was helpful and if they had any other comments.



## Mental Health Presentations: Feedback (cont.)

### Reasons for Attending



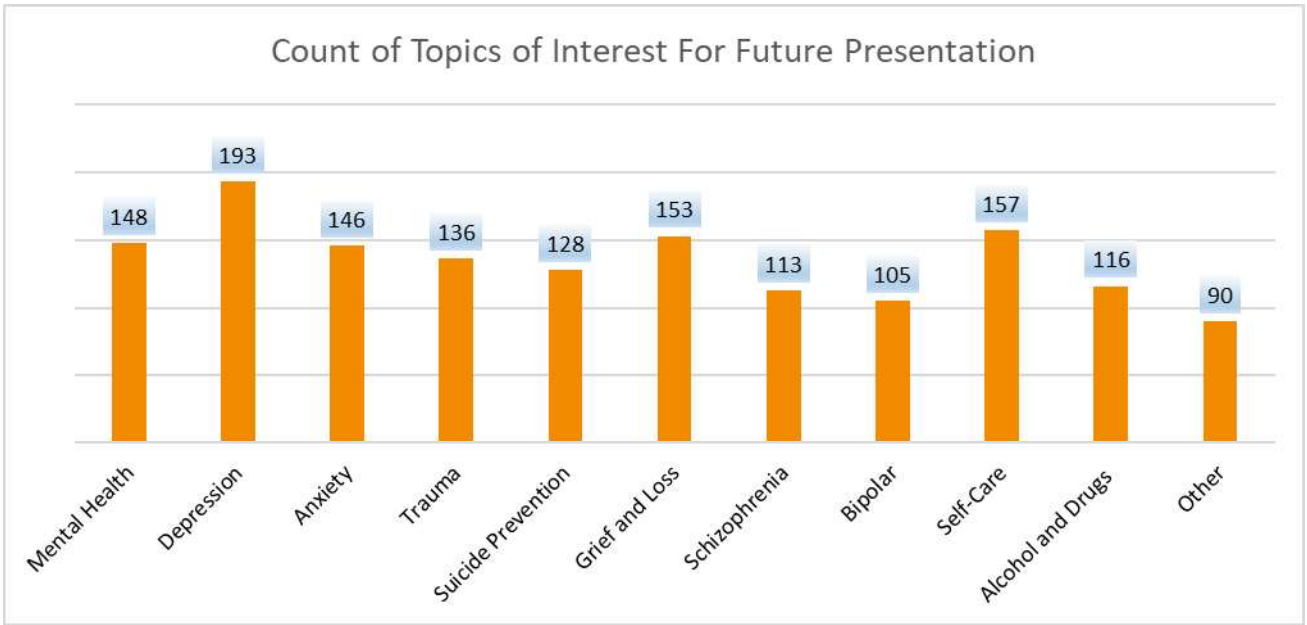

Out of 8,527 participants who completed the satisfaction survey, a randomized sample of 500 provided their reasons for attending the presentation. Participants could select more than one response.

The majority indicated that personal interest was their primary reason for attending, followed by a desire to help a family member. Among those who selected "other reason," the most common response was receiving an invitation from a friend or family member.

### Topics for Future Presentations

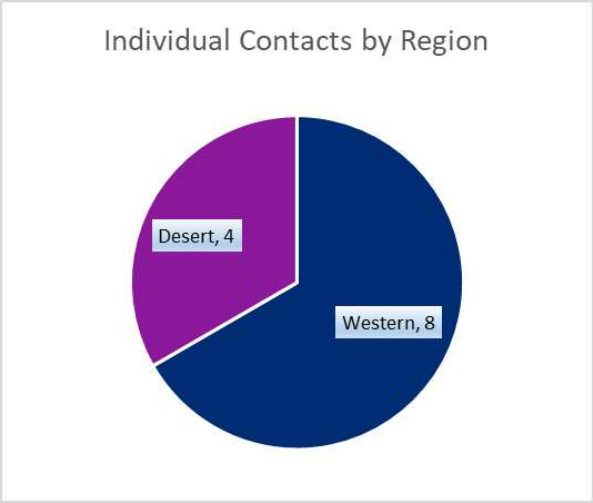
Among sample size of participants who completed the satisfaction survey, a majority expressed interest in learning about Depression, followed by Self-Care, and then Grief & Loss. Additional topics of interest not listed included Autism, Self-Esteem, and Obsessive-Compulsive Disorder. Participants were allowed to select more than one topic.

Feedback from these surveys will be considered by promoters when planning presentations on these topics for the 2024-2025 fiscal year.

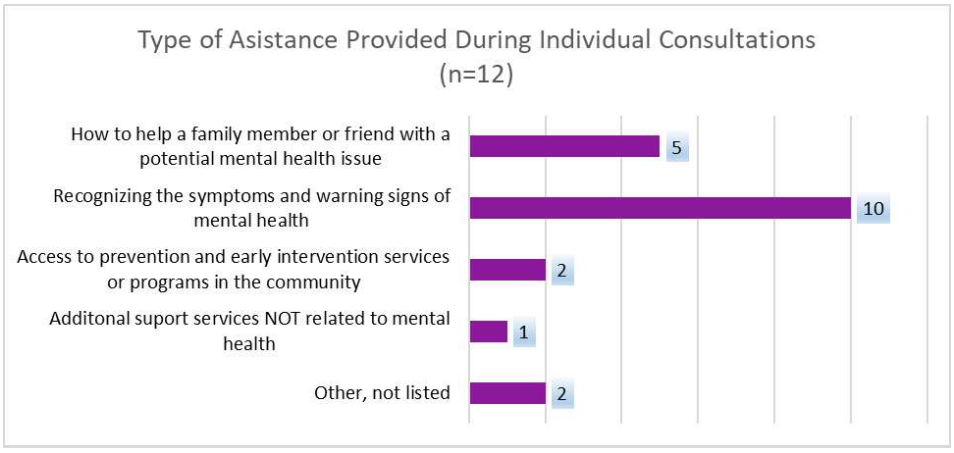


## *Promotores Hispanic/Latinx CMHPP*

### Individual Contacts: Type of Assistance




Individual contacts for the CMHP program are defined as when a promoter provides more in-depth one-on-one assistance upon outreach or after presentations to help an individual or family with specific needs and provide referrals to help meet those needs. For FY 2023-24, the Promotores Hispanic/Latinx CMHP program completed **12** individual consultations. Although not shown, all twelve individuals contacts were in-person and occurred as a result of presentations.




The chart above summarizes the types of consultation that were provided. A majority of mental health-related consultations involved recognizing the symptoms/warning signs of mental health issues and providing services to help a family member or friend with a potential mental health issue. Additionally, many participants asked for access to prevention and early intervention services or programs in the community. Only frequencies are displayed here, as there could have been multiple reasons for a consultation.

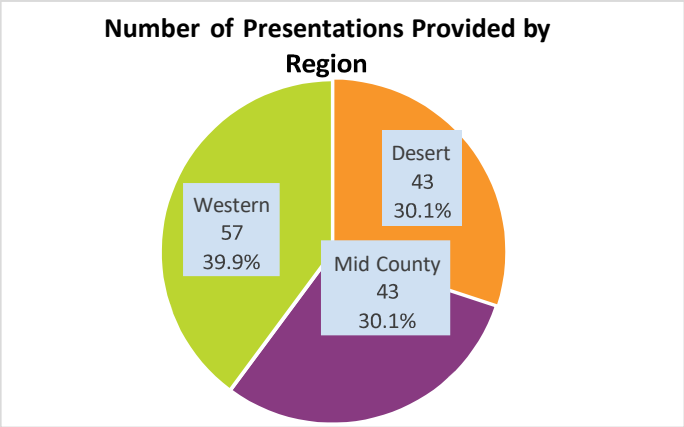
| Resources and Referrals Type | Count |
|---|---|
| **Mental Health Education Material** | 5 |
| **Medical Resources** | 1 |
| **Support Groups** | 1 |
| **Housing/Shelter/Homeless Shelter** | 1 |
| **Other Resources** *(2-1-1 Connect IE, CARES Line, Take-My-Hand)* | 24 |

The table to the left indicates the frequency of the types of referrals and resources provided as a result of the individual consultations. A total of **32** different resources and referrals were provided during the consultations. Participants requested information on mental health education materials, support groups, housing assistance, and other resources.

## *Native American CMHPP*

### Mental Health Presentations: Service Delivery and Attendance

From July 1st, 2023 to June 30, 2024 promoters for the Native American CMHP program provided a total of **143** 1-hour mental health presentations across the Desert, Mid-County, and Western regions of Riverside County. Most presentations were provided in person (78%) at schools/universities, libraries, coffee shops, recreation centers and tribal offices, with 21% conducted virtually through Zoom. Participants were informed about these presentations through various community outreach methods which included tabling, social media, putting fliers in community areas and reaching out to key community leaders at planning meetings.




A majority of presentations were provided in the Western region (39.9%), followed by the Desert (30.1%) and Mid-County (30.1%) regions. All presentations were provided in English.

Presentations were provided to **1,083** participants. Of these participants, 930 participants attended the presentation for the first time, 122 participants attended presentations two or more times (different presentation topics), and 31 participants did not report how many times they attended the presentation. The majority of participants attended presentations conducted by the Desert region (35.9%, n=389), followed by Mid-County (33.3%, n=361) and Western (30.7%, n=333) regions. While most of the participants were from the target region of the presentations, there were a small number of participants from out of county as well as some participants who attended presentations of a targeted region different than their region of residence. For these reasons, we have included an analysis of the cities of residence of the people (duplicated) that attended the presentations in each region below.

**# of people who attended presentations in Desert: 389 Cites of Residence**

| | |
|---|---|
| Banning | 208 (53.5%) |
| Beaumont | 84 (21.6%) |
| Cathedral City | 8 (2.1%) |
| Palm Springs | 8 (2.1%) |
| Thermal | 26 (6.7%) |
| Other Desert | 3 (0.7%) |
| Mid/West Riv. | 12 (3.1%) |
| Out of County | 7 (1.8%) |
| Not Reported | 33 (8.5%) |

**# of people who attended presentations in Mid-County: 361 Cites of Residence**

| | |
|---|---|
| Anza | 25 (6.9%) |
| Hemet | 28 (7.8%) |
| Lake Elsinore | 8 (2.2%) |
| Menifee | 7 (1.9%) |
| San Jacinto | 217 (60.1%) |
| Temecula | 31 (8.6%) |
| Other Mid Cty. | 15 (4.2%) |
| Out of County | 2 (0.6%) |
| Not Reported | 28 (7.8%) |

**# of people who attended presentations in Western: 333 Cites of Residence**

| | |
|---|---|
| Corona | 3 (0.9%) |
| Jurupa Valley | 1 (0.3%) |
| Moreno Valley | 41 (12.3%) |
| Riverside | 263 (79%) |
| Other Desert | 1(0.3%) |
| Other Mid Cty. | 1(0.3%) |
| Out of County | 19 (5.7%) |
| Not Reported | 4 (1.2%) |

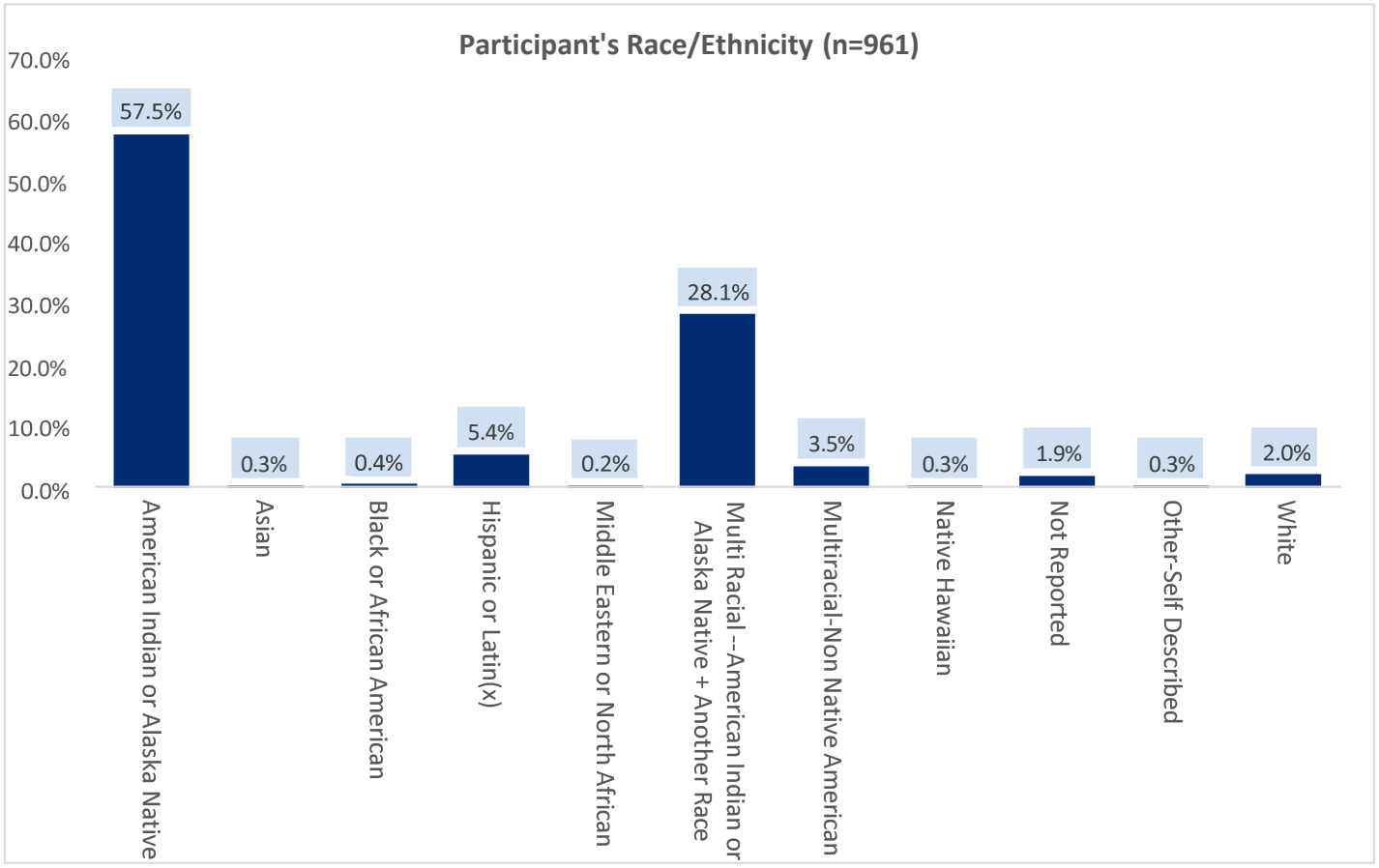
## Mental Health Presentations: Topics

Countywide, a majority of the presentations provided by promoters in Native American CMHPP was on General Mental Health (48.3%) followed by Self Care (17%) of presentations.

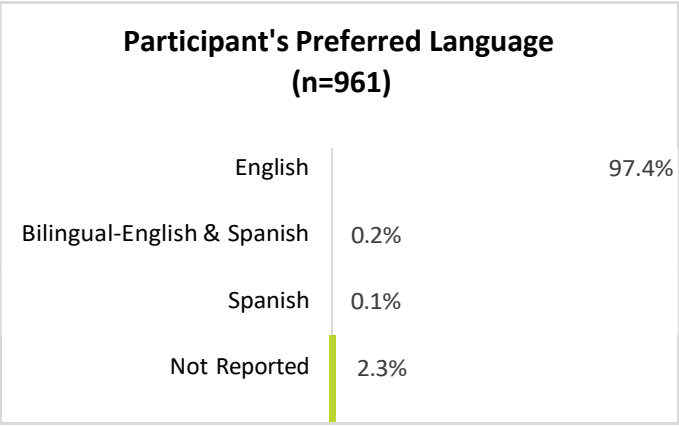
| Topic | # and % of Presentations | Topic | # and % of Presentations |
|---|---|---|---|
| Anxiety | 13 (9.1%) | Mental Health and Stigma | 7 (4.9%) |
| Bullying | 2 (1.4%) | Self Care | 24 (16.8%) |
| Depression | 14 (9.8%) | Substance Use and Abuse | 2 (1.4%) |
| Grief and Loss | 7 (4.9%) | Suicide Prevention | 2 (1.4%) |
| **Mental Health 101** | **69 (48.3%)** | Trauma | 3 (2.1%) |

## Mental Health Presentations: Demographics

This section highlights the basic demographics of participants provided for FY 2023-24. All numbers are based on the unduplicated count of **961** participants (including participants who did not report the number of times they attended a presentation - Desert n=323, Mid-County n=312, and Western n=326). Countywide 85.6% of the participants served were American Indian or Alaskan Native (or American Indian or Alaskan Native + Another Race ). While the program was focused towards individuals from the Native American community, the program welcomed anyone who felt they would benefit.

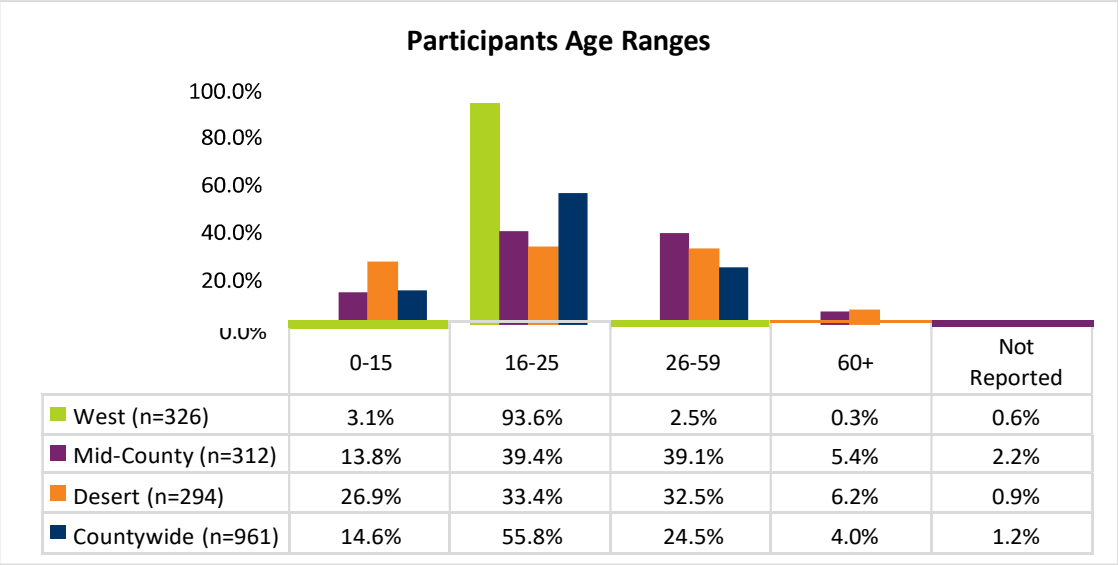


## Mental Health Presentations: Demographics cont.



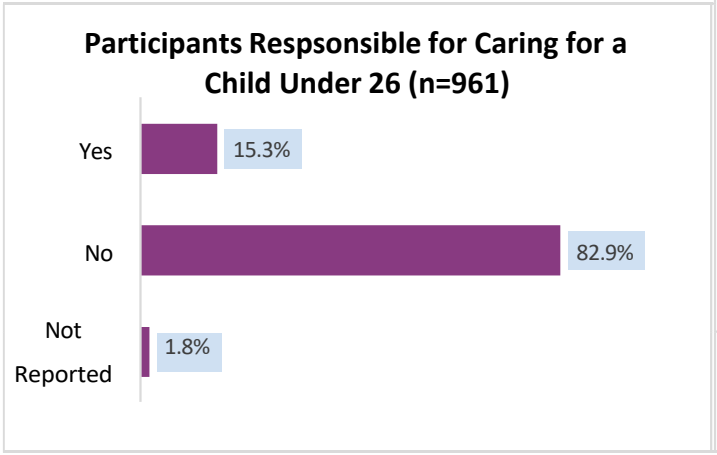

Countywide, a majority of participants indicated English as their primary language (97%).

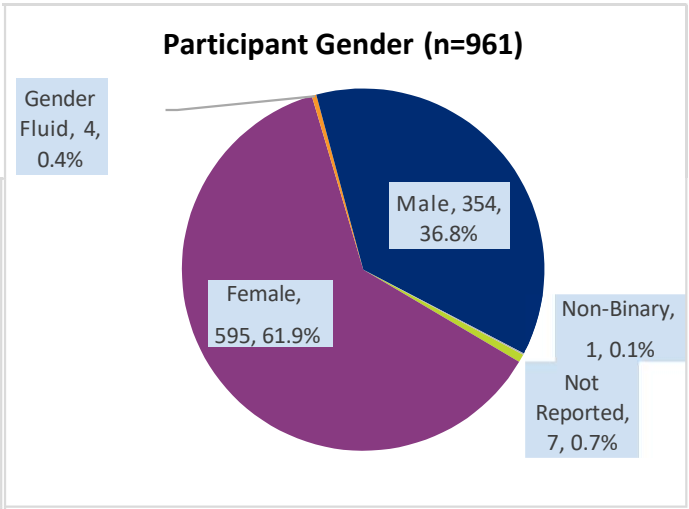
Since there were differences in age demographics by region, the graph below shows participant age by region. Countywide, a majority of participants reported they were 16-25 years old (56%).




| | 0-15 | 16-25 | 26-59 | 60+ | Not Reported |
|---|---|---|---|---|---|
| West (n=326) | 3.1% | 93.6% | 2.5% | 0.3% | 0.6% |
| Mid-County (n=312) | 13.8% | 39.4% | 39.1% | 5.4% | 2.2% |
| Desert (n=294) | 26.9% | 33.4% | 32.5% | 6.2% | 0.9% |
| Countywide (n=961) | 14.6% | 55.8% | 24.5% | 4.0% | 1.2% |

Countywide, 15% of participants reported they were responsible for caring for at least one child aged 25 and younger.




Countywide, a majority of participants reached by presentations were female (62%).

Countywide (not shown in this graph) 2.5% of participants identified as LGBTQ.

## Mental Health Presentations: Satisfaction and Feedback

After the presentation, participants were encouraged to complete a satisfaction survey which asked about their satisfaction with the presentation delivery/cultural sensitivity, class content, and their confidence in talking about and seeking help for their mental health or the mental health of family members/friends. They were asked on a scale of 1-5 (1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree) about how much they agreed with the statements in the survey. 1,080 participants completed the survey. Surveys of people who attended more than one presentation were included as they may have had a different experience each time.

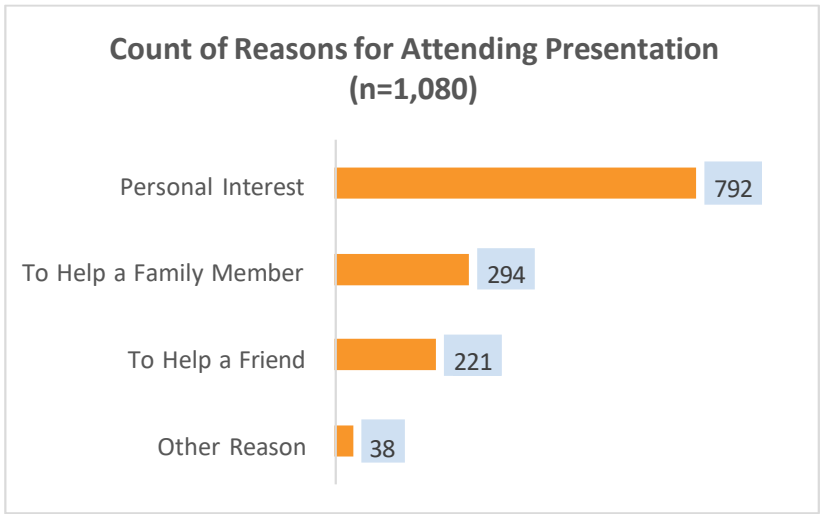
As shown below, a majority of participants agreed or strongly agreed with all statements in the survey—that they felt able to find help and get resources, that they could share the information with family and friends, that they got a better understanding of mental health issues in a culturally relevant way.

| Question (n=1,080) | Avg Score | 1 | 2 | 3 | 4 | 5 | No resp. |
|---|---|---|---|---|---|---|---|
| The information presented was easy to understand | **4.66** | — | 1 (0.1%) | 42 (3.9%) | 283 (26.2%) | **754 (69.8%)** | — |
| The presenter understands the needs of my community | **4.58** | — | 2 (0.2%) | 51 (4.7%) | 343 (31.8%) | **684 (63.3%)** | — |
| I would recommend to my friends and family members that they attend a presentation like this in the future | **4.55** | — | 2 (0.4%) | 57 (5.3%) | 364 (33.7%) | **655 (60.6%)** | — |
| The material in this presentation gave me a better understanding of the early signs of mental health issues within my culture | **4.60** | — | 1 (0.1%) | 71 (6.6%) | 287 (26.7%) | **717 (66.4%)** | 4 (0.4%) |
| **As a result of this presentation** | | | | | | | |
| I feel I am better able to talk about this topic with my family and friends | **4.45** | 4 (0.4%) | 8 (0.7%) | 101 (9.4%) | 355 (32.9%) | **608 (56.3%)** | 4 (0.4%) |
| I know mental illness can be managed and treated | **4.53** | — | 3 (0.3%) | 69 (6.4%) | 358 (33.1%) | **648 (60.0%)** | 2 (0.2%) |
| I feel comfortable seeking help for a family member, friend, or myself | **4.49** | 3 (0.3%) | 4 (0.4%) | 86 (8.0%) | 349 (32.3%) | **633 (58.6%)** | 5 (0.5%) |
| I know where to seek resources for a family member, friend, or myself | **4.63** | 1 (0.1%) | — | 61 (5.6%) | 277 (25.6%) | **737 (68.2%)** | 5 (0.5%) |

## Mental Health Presentations: Comments

The participants' comments on the satisfaction survey also highlight how well CMHPP was in the community. Below are some of the comments made by participants when asked what was helpful and if they had any other comments.

## Mental Health Presentations: Reasons for Attending

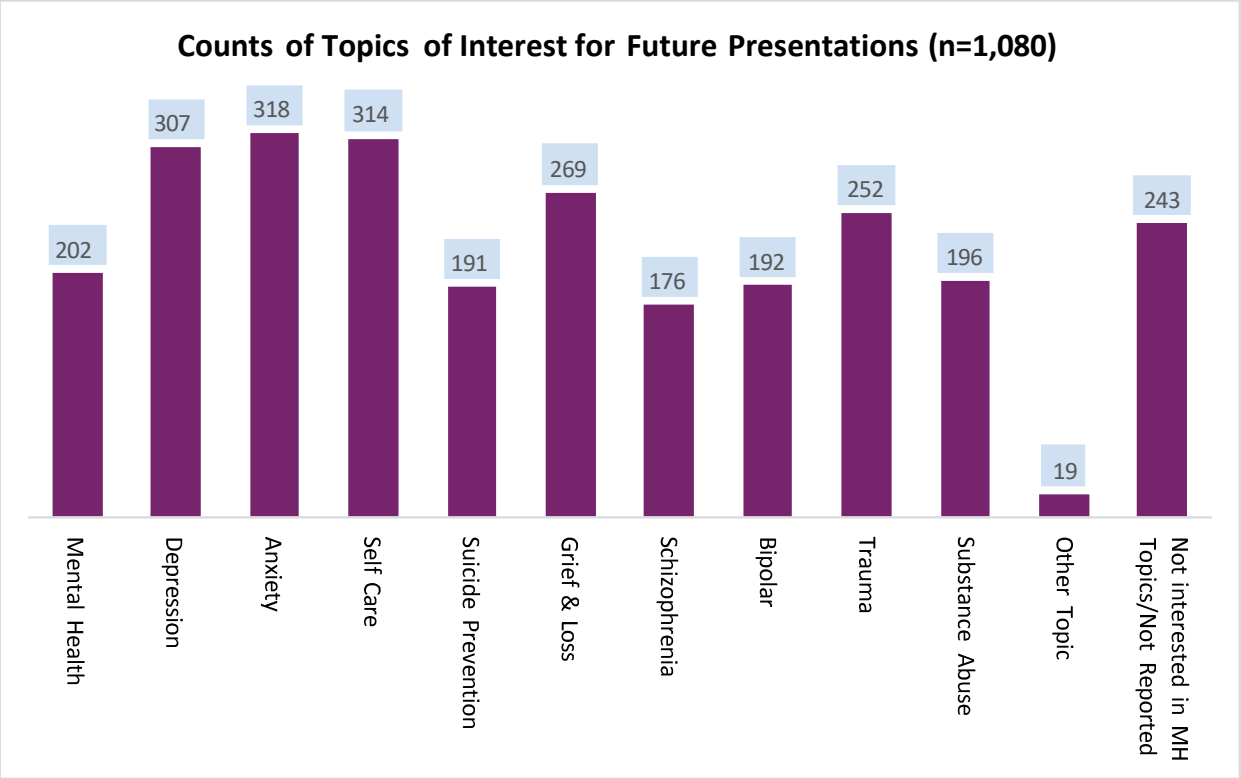



Of the 1,080 people completing the survey, a majority of the people indicated personal interest as a reason for attending the presentation. People were allowed to select more than one response.

For participants that marked "other reason," the most common reasons were that it was required by their school, that they attended with their friend or that they were interested in helping the community.

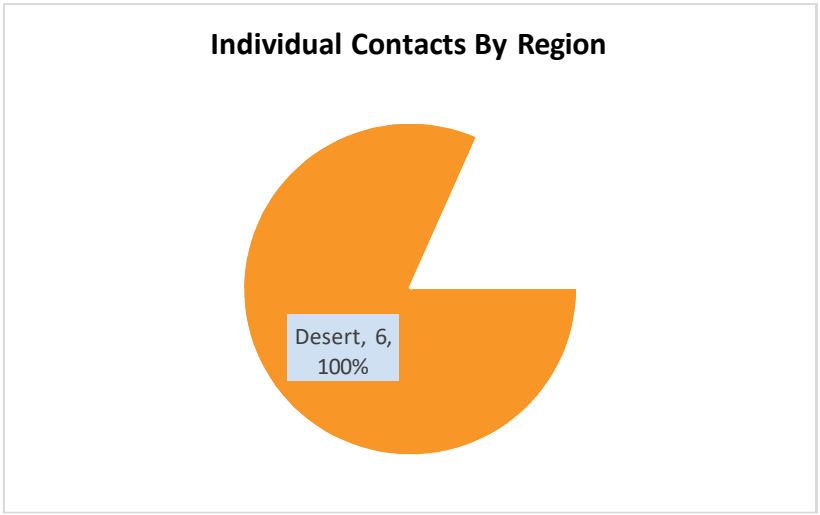
## Mental Health Presentations: Topics for Future Presentations

A majority of participants expressed interest in learning about anxiety followed by self care, depression and grief/loss.




## Individual Contacts

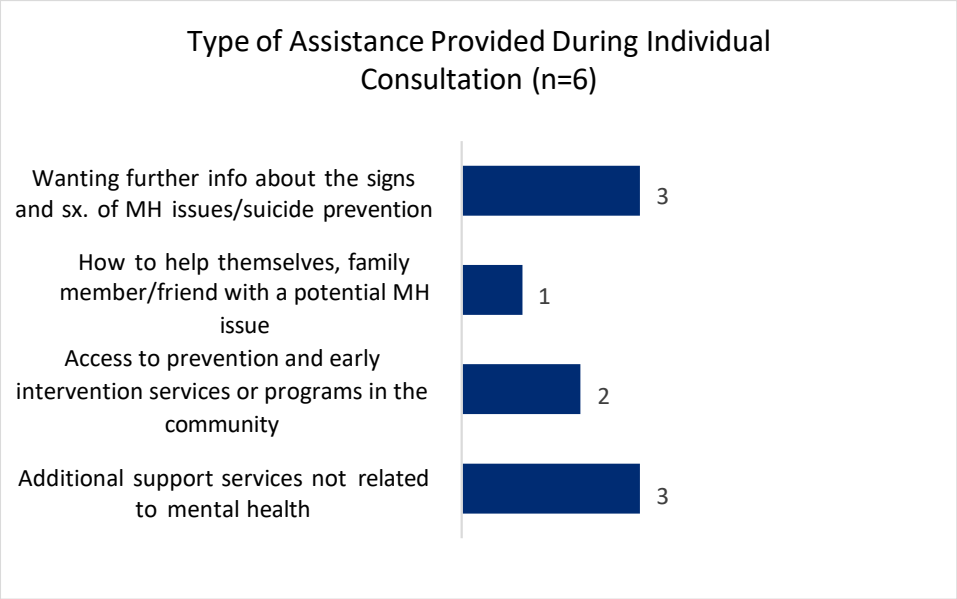
Individual contacts for the CMHP program are defined as when a promoter provides more in depth one-on-one assistance upon outreach or after a presentation to help an individual or family with specific needs and provides referrals to help meet those needs. For FY 2023-24, the Native American CMHP program completed **6** individual consultations. All individual contacts took place face-to-face in person, following the presentations.




The majority of the individual contacts took place in the Desert region of Riverside County (100%).

## Individual Contacts cont.

The chart below summarizes the types of assistance that were provided. A majority of mental health related consultations involved wanting further information about the signs and symptoms of mental health issues and suicide prevention. Only frequencies are displayed here, as there could have been multiple reasons for a consultation.



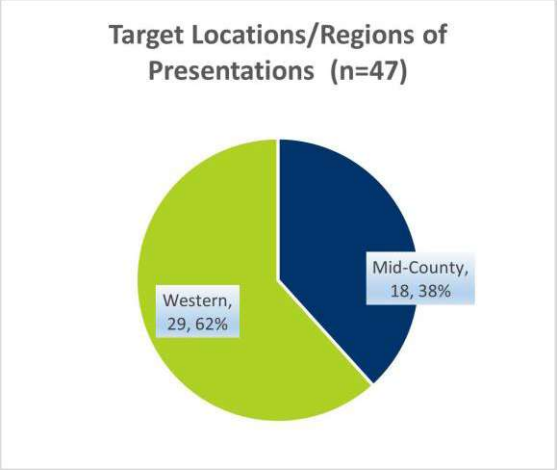

The table below shows the frequency of the type of referrals and resources provided as a result of the individual consultation. A total of **8** different resources and referrals were provided as a result of the consultations.

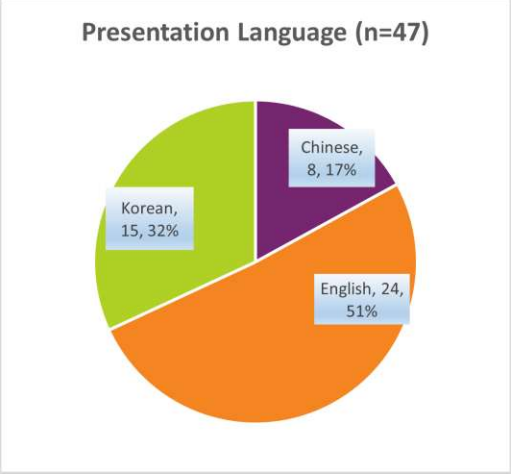
| Resources and Referrals Type | Count |
|---|---|
| **Food (***HELP Inc, WIC)* | 3 |
| **Support Group** (*Soboba talking circles*) | 1 |
| **Cares Line** | 1 |
| **Behavioral Health Specialist** (RSBCIHI) | 1 |
| **Native Challenge** | 1 |
| **PEI Program** *(Celebrating Families)* | 1 |

## *Asian American/Pacific Islander CMHPP*

### Mental Health Presentations: Service Delivery and Attendance

From July 1st, 2023 to June 30, 2024 promoters for the Asian American/Pacific Islander CMHP program provided a total of **47** 1-hour mental health presentations across the Desert, Mid-County, and Western regions of Riverside County. The majority of presentations targeted the Western region of Riverside County (61.7%). Additionally, a little over half (51%) of the 47 presentations were targeted for the English-speaking community, followed by the Korean-speaking community (32%), and the Chinese-speaking community (17%).




For FY 2023-24, there was a total of **1,028** attendees for the presentations. Out of the 1,028 attendees, 915 attendees had completed a demographic form with 144 people who had attended more than one presentation. As a result, **771** unique individuals are included within the unduplicated count for the demographics portion of the report.

### City of Residence

As some presentations were available virtually, it was possible that participants could have joined from outside of Riverside County. The table below reports on the zip codes of the 771 participants who provided demographic information. Of the people who provided their zip code information, the majority of participants reside in the cities of Corona and Riverside. The Asian American/Pacific Islander CMHP program also reached individuals outside of Riverside County, such as San Bernardino, Los Angeles, Orange and many other counties.

| City of Residence Riverside County | n, (%) | City of Residence Outside of Riverside County | n, (%) |
|---|---|---|---|
| **Riverside** | **188 (24.4%)** | San Bernardino County | 28 (3.6%) |
| **Corona** | **86 (11.2%)** | Los Angeles County | 38 (4.9%) |
| Murrieta | 59 (7.7%) | Orange County | 20 (2.6%) |
| Temecula | 40 (5.2%) | Other/Not Reported* | 231 (30.0%) |
| Moreno Valley | 20 (2.6%) | | |
| Winchester | 15 (1.9%) | | |
| Other Cities in Riverside County | 76 (9.9%) | | |

**Includes participants who did not respond to this question and those who lived outside of the cities/counties of interest above (e.g., Santa Barbara County, etc.).*

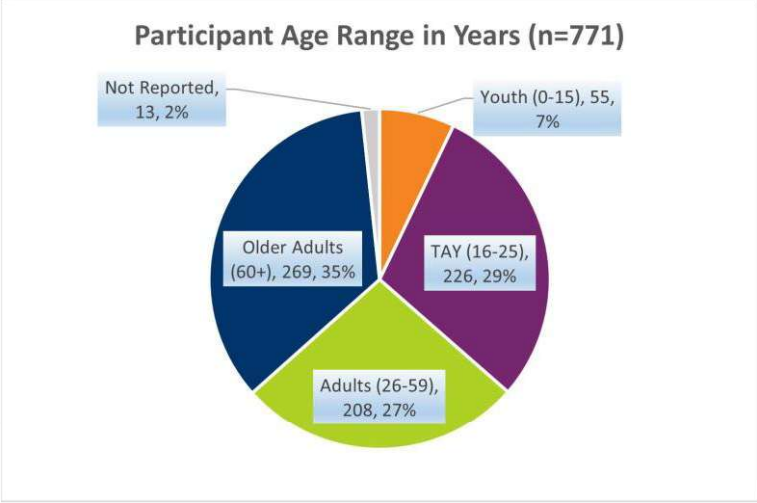
## Mental Health Presentations: Service Delivery and Attendance cont.

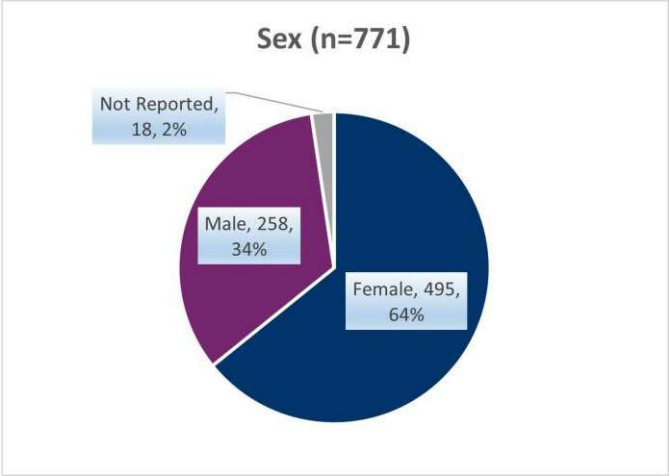
Countywide, most of the presentations that were done by promoters from the Asian American/Pacific Islander CMHP program were on the topic of Mental Health (40.4%), followed by Self-Care (21.3%). Some presentations were tailored to specific audiences. For example, for the Mental Health topic, promoters presented on material for Children's Mental Health.

| Topic | # and % of Presentations | Topic | # and % of Presentations |
|---|---|---|---|
| Anxiety | 2 (4.3%) | Self-Care | 10 (21.3%) |
| Depression | 2 (4.3%) | Stress Management | 5 (10.6%) |
| Mental Health | 19 (40.4%) | Suicide Prevention | 3 (6.4%) |
| Psychosis | 1 (2.1%) | Trauma | 5 (10.6%) |

## Mental Health Presentations: Demographics

This section highlights the basic demographics of participants provided for FY 2023-24. There was a total of 915 individuals who provided demographic information; however, the following demographic data is based on the unduplicated count of participants (**n=771)**. Additionally, all of the demographic data is analyzed on a countywide level.

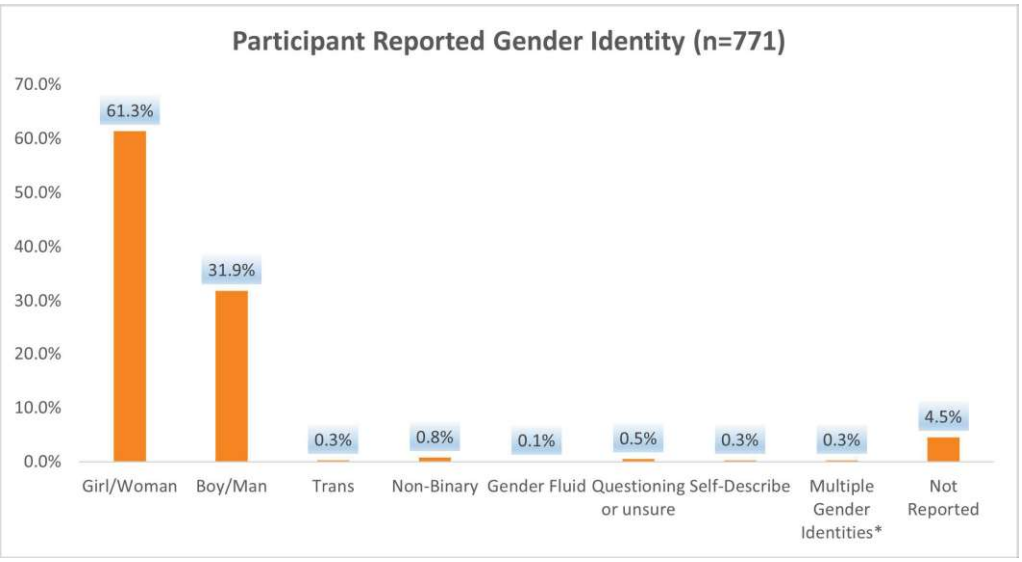


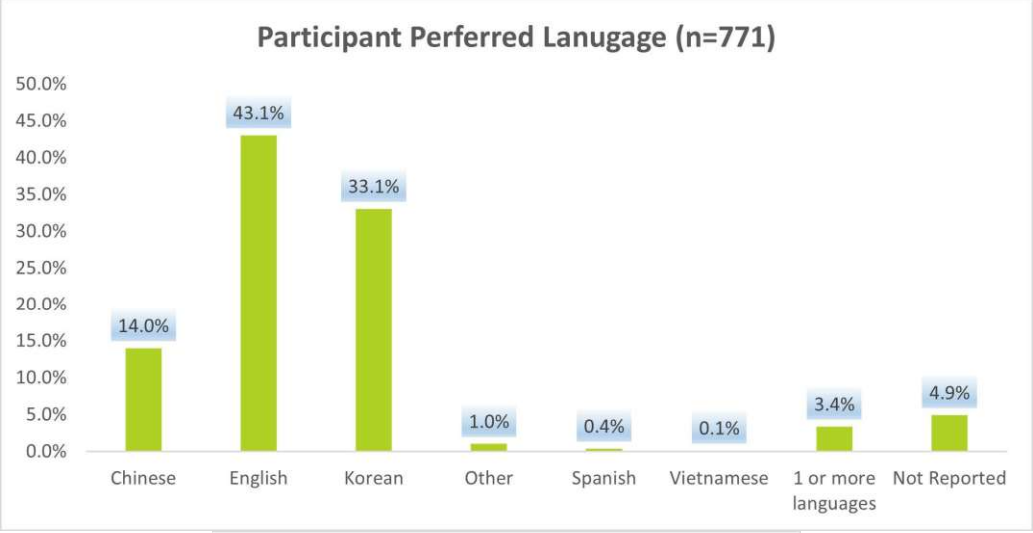



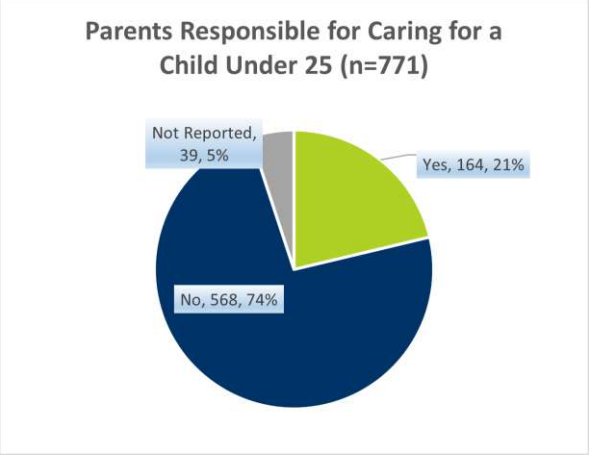

There was a wide variety of ages of those who attended the CMHP Asian American/Pacific Islander presentations. A little over one-third of participants reported being in the 60+ age group (35%), closely followed by the Transitional Age Youth (TAY) age group of 16-25 years old (29%). Almost one-third of participants identified being in the 26-59 age group (27%) and lastly, participants identified being in the 0-15 age group (7%). In addition, the majority of participants who attended the presentations reported their sex as female (64%), followed by male (34%).

## Mental Health Presentations: Demographics cont.

Countywide, most participants identified their gender as Girl/Woman (61.3%), followed by Boy/Man (31.9%). In addition, there was variation in participants' preferred languages with about 43.1% of participants having a preference for English, followed by Korean (33.1%), Chinese (14.0%), and more than one language as their preferred language (3.4%). Notably, a majority of participants said that they are not responsible for caring for a child who is 25 years old and under (74%).

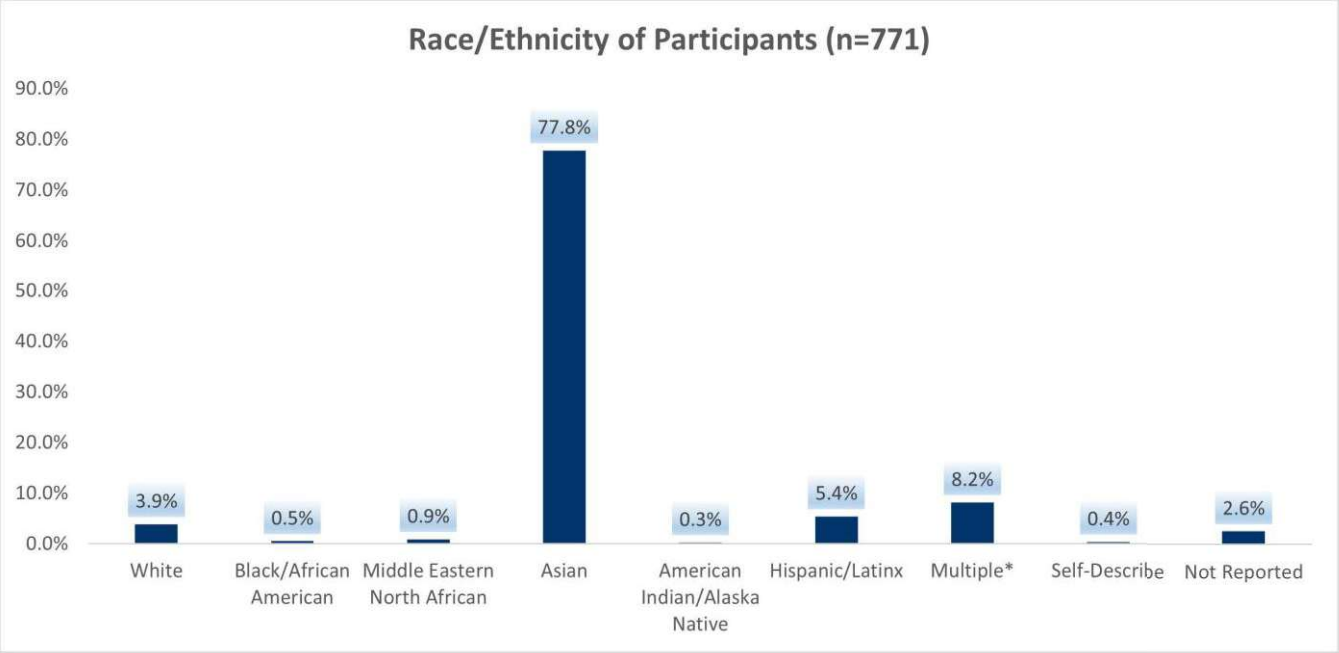


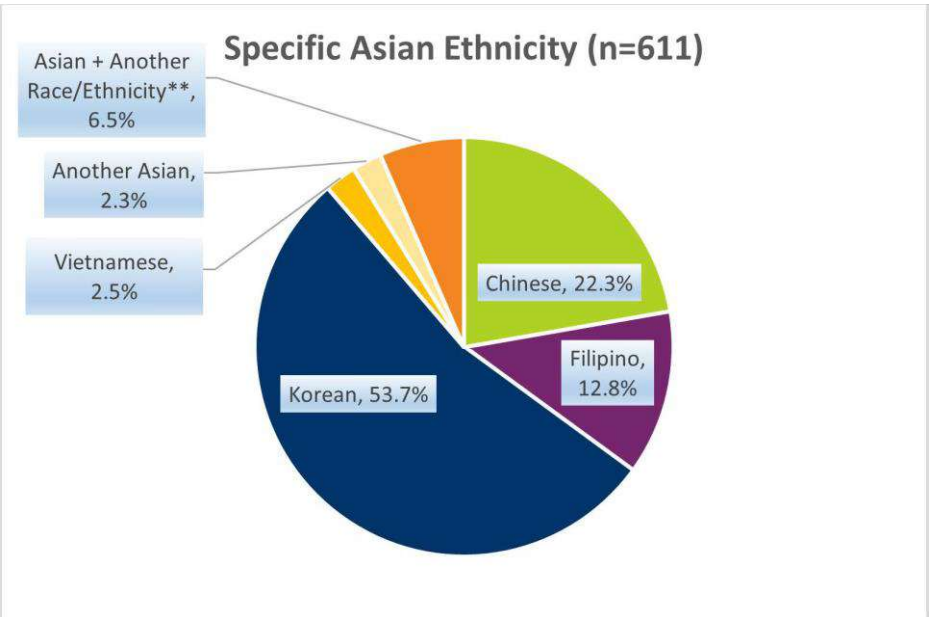



## Mental Health Presentations: Demographics cont.

Most respondents identified their race/ethnicity as Asian (77.8%), followed by Multiple Race/Ethnicities (8.2%). Within the breakdown of the categories for the Asian race/ethnicity group, most individuals identified as Korean (53.7%), followed by Chinese (22.3%), Filipino (12.8%), Asian + Another Race/Ethnicity (6.5%), Vietnamese (2.5%), and Another Asian ethnicity (2.3%). Although not shown here, the majority of participants identified as Heterosexual or Straight (70.9%). Lastly, the majority of participants indicated that they did not have a disabling condition (88.2%) nor a veteran (90.8%).




**Includes individuals who identify with multiple race/ethnicities.*




***Includes individuals who identified generally as Asian or a specific Asian identity + another race/ethnicity.*

## Mental Health Presentations: Satisfaction and Feedback

After the presentation, participants were encouraged to complete a satisfaction survey which asked about their satisfaction with the promoter, class content, and their confidence in talking about and seeking help for their mental health. They were asked on a scale of 1-5 *(1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree*) about how much they agreed with the statements in the survey. There was a total of **913** participants who completed the satisfaction survey. Surveys of people who attended more than one presentation were included as they may have had a different experience each time they attended a new presentation.

The average rating scores for all statements in the survey were above a score of 4, indicating that most participants agreed with the statements on seeking help and finding resources, being able to talk about the presentation topic with friends and family, and having a better understanding of mental health issues.

| Question (n=913) | Avg Score | 1 | 2 | 3 | 4 | 5 | No Resp. |
|---|---|---|---|---|---|---|---|
| The information presented was easy to understand | **4.44** | 11 (1.2%) | 5 (0.5%) | 27 (3.0%) | 158 (17.3%) | **695 (76.1%)** | 17 (1.9%) |
| The presenter was enthusiastic when presenting the information | **4.58** | 11 (1.2%) | 7 (0.8%) | 55 (6.0%) | 199 (22.8%) | **629 (68.9%)** | 12 (1.3%) |
| I would recommend to my friends and family members that they attend a presentation like this | **4.58** | 9 (1.0%) | 7 (0.8%) | 67 (7.3%) | 184 (20.2%) | **635 (69.6%)** | 11 (1.2%) |
| The material in the presentation gave me a better understanding of the early signs of mental health issues | **4.59** | 9 (1.0%) | 11 (1.2%) | 50 (5.5%) | 197 (21.6%) | **631 (69.1%)** | 15 (1.6%) |
| **As a result of this presentation** | | | | | | | |
| I feel I am better able to talk about this topic with my family and friends | **4.46** | 10 (1.1%) | 10 (1.1%) | 86 (9.4%) | 238 (26.1%) | **550 (60.2%)** | 19 (2.1%) |
| I know mental illness can me managed and treated | **4.60** | 7 (0.8%) | 5 (0.5%) | 46 (5.0%) | 223 (24.4%) | **612 (67.0%)** | 20 (2.2%) |
| I feel comfortable seeking help for a family member or myself | **4.47** | 8 (0.9%) | 17 (1.9%) | 87 (9.5%) | 213 (23.3%) | **569 (62.3%)** | 19 (2.1%) |
| I know where to seek resources for a family member or myself | **4.54** | 11 (1.2%) | 8 (0.9%) | 55 (6.0%) | 232 (25.4%) | **584 (64.0%)** | 23 (2.5%) |

## Mental Health Presentations: Comments

The participants' comments on the satisfaction survey also highlight how well received the CMHP program was in the community. Below are some of the comments made by participants when asked what was helpful about the presentation and if they had any other comments about the presentations.

"I think that it was very helpful to hear terms such as 'kapwa' and to hear mental health described as affected by the collective history of my community."

"Looking forward to attending many more mental health related seminars in the future. Much appreciated!"

"Learned different ways to cope with stress."

"The mindset to think about things again and make an effort to put into practice."

"Learning about how different Asian communities handle trauma and mental health issues."

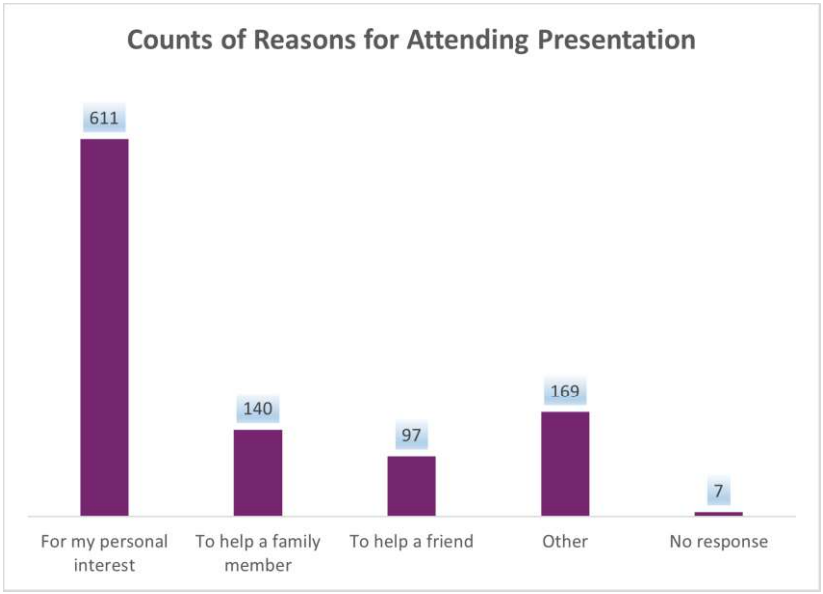
"Made easy for children to understand and kept them engaged with game."

"A warm and welcoming space was created to allow us to be vulnerable and open."

"The presentation was good at bridging some gaps and making the intersectionality between mental health, trauma, and layers of colonization + systemic violence."

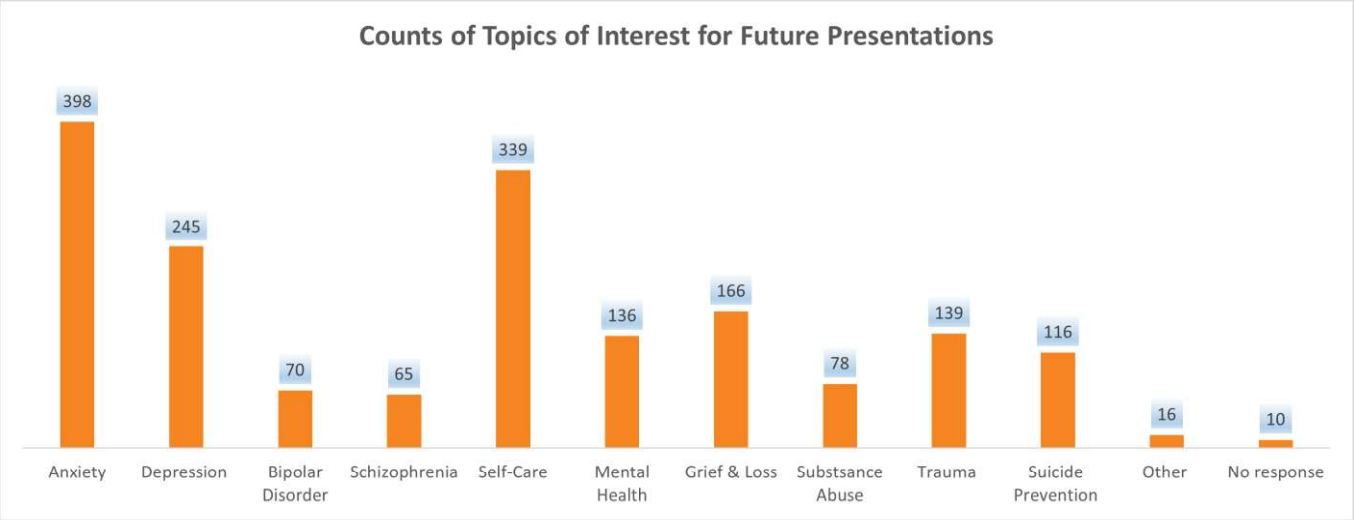
## Mental Health Presentations: Reasons for Attending

Of the 913 people who completed the satisfaction survey, **906** participants provided reasons as to why they attended a CMHP AAPI presentation. The most frequently chosen response among participants was "for my personal interest".



## Mental Health Presentations: Topics for Future Presentations

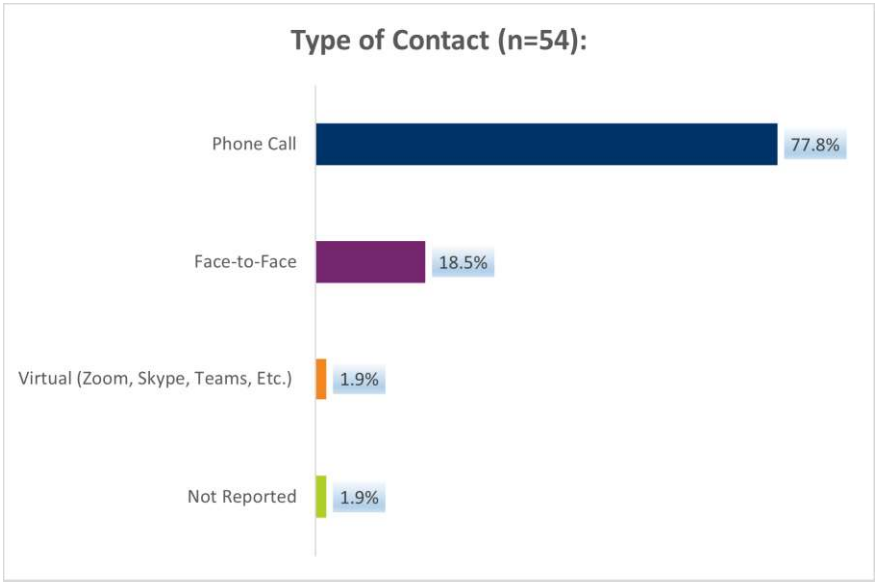
Of the 913 people who completed the satisfaction survey, **903** participants expressed interest in learning about different topics in future presentations. The most frequently chosen response for a topic of interest for future presentations was anxiety, closely followed by self-care.




## Individual Contacts

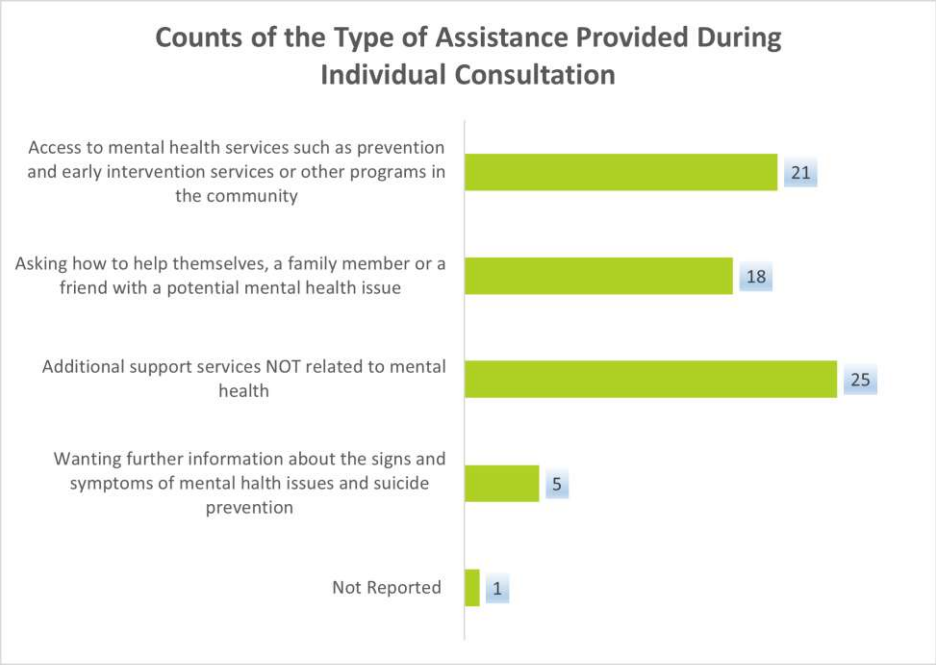
Individual contacts for the CMHP program are defined as when a promoter provides more in-depth, one-on-one assistance upon outreach or after presentations to help an individual or family with specific needs and provide referrals to help meet those needs. For FY 2023-24, the Asian American/Pacific Islander CMHP program completed **54** individual consultations.

The most frequent type of contact that a promoter made with CMHP participants was through phone call (77.8%), followed by face-to-face interaction (18.5%), and then through virtual platforms such as Zoom, Skype, Teams, etc. (1.9%).



## Individual Contacts cont.

Most participants indicated that they received more than one type of assistance during an individual consultation. This means that an individual had assistance with any of the types of assistance listed down below. In addition, the most frequent type of resource/referral that participants received was mental health education material, followed by individuals who were referred to a private mental health service, such as the SSG-APCTC's Riverside Counseling Center.




| Resources and Referrals Type | Count |
|---|---|
| **Mental Health Education Material** | 17 |
| **Prevention and Early Intervention Program(s)** | 9 |
| **Housing/Utilities Assistance** | 3 |
| **Food/Clothing Assistance** | 3 |
| **Employment/Education Services** | 1 |
| **Transportation Services** | 2 |
| **Medical Resources** | 6 |
| **Support Groups** | 3 |
| **Referral to Private Mental Health Services** *(SSG-APCTC's Riverside Counseling Center)* | 16 |
| ***211*** | 2 |
| ***CARES*** | 1 |
| ***988/Helpline*** | 1 |
| **Other Resources** *(SSDI resources, disability services, legal inquiries, etc.)* | 25 |

## *Middle Eastern/North African CMHPP*

# Promoter Training

For FY 2023-24, there were two promoters from Sahaba Initiative's MENA CMHP program who completed all 40 hours of required training as required by RUHS-BH MHSA PEI.

**Topics included:**

- CMHPP overview
- Community Outreach Strategies
- Presentation Tips
- Mental Health Basics
- Mental Health Needs of MENA
- Suicide Prevention, Anxiety
- Trauma
- Grief and Loss
- Psychosis/Schizophrenia
- Bipolar Disorder
- Depression
- Substance Misuse
- Self-Care and Wellness

# Director's Feedback

The program director had a very positive experience training the community mental health promoters and preparing them for program implementation in the community. The promoters were highly engaged throughout the training days and asked thoughtful questions to help deepen their understanding of the material.

One promoter had a reaction of discomfort to the psychosis and bipolar disorder presentations, and shared that the reaction was largely due to learning about more severe case examples of psychosis and bipolar disorder during the discussion portion of the training. The director provided support by welcoming discussion about their reactions, checking in with them on the day of and afterwards, and responding to any questions that came up.

Additionally, the promoters demonstrated great skill when presenting the material back during practice presentations, not only when it came to presentation style and presence, but also in conveying the relevant information appropriately and accurately. The promoters found the training beneficial and they demonstrated great enthusiasm for bringing the presentations to the community. Overall, the director felt the training went well.

# Promoter Training cont.

## Promoter's Feedback

After completion of their 40 hour training, promoters participated in a survey in which they rated their agreement with statements on a scale from 1-5 (1-strongly disagree to 5-strongly agree). Their responses are shown in the table below. The promoters strongly agreed that the trainings were effective and helpful in their development as a promoter. They are confident in their knowledge of mental health, their ability to work with the community, and answer questions on mental health issues in a culturally competent way. In addition, the promotor provided comments based on the trainings.

| Question | Avg. Score |
|---|---|
| I felt like an active participant in my development as a Promotor. | 5 |
| The training will help me to be an effective Promotor. | 5 |
| I feel able to utilize the materials presented in the training. | 5 |
| The trainers were knowledgeable and communicated clearly and effectively. | 5 |
| How would you rate your ability to do community mental health presentations? | 5 |
| How would you rate your ability to talk to people and answer questions about mental health issues? | 5 |
| How would you rate your knowledge of community resources and your ability to provide these resources to the community? | 5 |
| How would you rate your overall knowledge of mental health and about being a Promotor? | 5 |
| How would you rate your ability to understand cultural and linguistic diversity issues? | 5 |

Riverside University HEALTH SYSTEM Behavioral Health

# MHSA Prevention and Early Intervention (PEI)

## PEI Suicide Prevention Trainings

*Mental Health First Aid (MHFA)*

*safeTALK*

*Know the Signs*

*Applied Suicide Intervention Skills Training (ASIST)*

## FY 2023-2024 Annual Report

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## OVERVIEW DESCRIPTION OF TRAININGS

Riverside County currently offers four suicide prevention trainings through the help of the Mental Health Service Act Prevention and Early Intervention (MHSA PEI) Department.

- **Applied Suicide Intervention Skills Training (ASIST)** is a two-day workshop designed for members of all caregiving groups. Family, friends, and community members may be the first to encounter an at-risk individual, but have little or no training to help. ASIST emphasizes the importance of learning suicide first-aid to keep at-risk individuals safe and to seek further help if needed. ASIST also helps individuals in formal helping roles with professional development so that they are better prepared to perform suicide first aid help when providing care to others. After completing ASIST, participants will know how to use a suicide intervention model to identify individuals with suicidal thoughts and develop a safety plan with them.

- **The Mental Health First Aid (MHFA)** program is an 8-hour long interactive session and can be conducted in three different ways: one-day 8-hour seminar, two-day 4-hour seminar, or a four-day 2-hour seminar. The program covers risk/protective factors, warning signs of mental health problems, prevalence data, stigma, assessment, intervention, and how to connect individuals in crisis with appropriate care. Additionally, the MHFA program provides evidence-based professional, peer, social, and self-help resources for individuals with a mental health illness. For specific target populations, there are two courses that are offered for training and certification, the Adult MHFA and the Youth MHFA. Each certification must be renewed every three years.

- **safeTALK** is a half-day training program that teaches participants to recognize and engage with individuals who possibly have suicidal thoughts and to connect them with community resources. safeTALK emphasizes safety while challenging the stigma in openly discussing suicide. It is recommended that individuals trained in ASIST or other suicide prevention programs to be at all safeTALK trainings. This program provides gradual exposure to practice actions and to help participants understand how false societal beliefs can cause otherwise caring and helpful people to miss, dismiss, or avoid warning signs of suicide. safeTALK also helps participants practice the TALK step actions in overcoming these barriers.

- **Know the Signs** is a statewide suicide prevention social marketing campaign built on three key messages: *"Know the signs. Find the words. Reach out."* This campaign is intended to educate on how to recognize the warning signs of suicide, how to find the words to have a direct conversation with someone in crisis, and where to find professional help and resources.

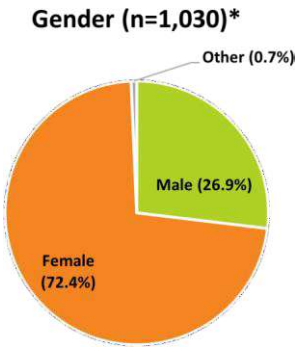
The goal for MHSA PEI is to have various Riverside County department employees and community-based organizations trained in these suicide prevention courses so that each department or organization has the ability to host the trainings for communities at large.

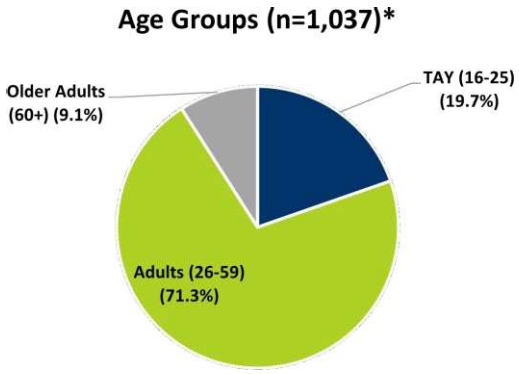
## EXECUTIVE SUMMARY

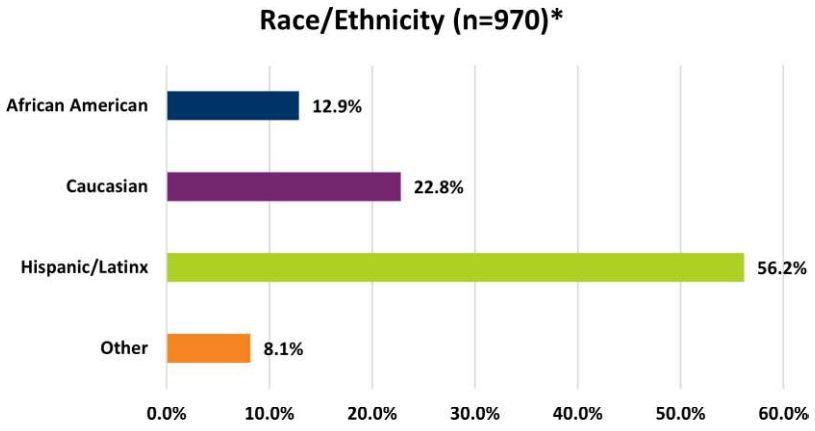
### FY 2023-2024 TOTAL NUMBER OF SUICIDE PREVENTION TRAININGS: 84

| Know the Signs | Mental Health First Aid | ASIST | safeTALK |
|---|---|---|---|
| **17** Total Number of Trainings | **17** Total Number of Trainings | **19** Total Number of Trainings | **31** Total Number of Trainings |

### FY 2023-2024 TOTAL NUMBER OF PARTICIPANTS TRAINED: 1,150



**<u>Note:</u> Some categories are not shown here, including not reported/unknown.*

# EXECUTIVE SUMMARY (cont.)

## FY 23-24 PEI SUICIDE PREVENTION TRAININGS OVERVIEW

Mental Health FIRST AID from NATIONAL COUNCIL FOR MENTAL WELLBEING

- Total of 17 trainings for FY 23-24
- Audience reached was 231 participants with 225 participants (97.4%) who completed the training
- The smallest audience size for a training was 6 people while the largest audience size for a training was 28 people

- Total of 31 trainings for FY 23-24
- Total audience reached was 503 with *all* participants completing the training (100%)
- On a scale of 1 (i.e., very bad) to 10 (i.e., very good), the average rating for this training was 9.6

SUICIDE safeTALK

Pain Isn't Always Obvious KNOW THE SIGNS Suicide Is Preventable.org

- Total of 17 trainings for FY 23-24
- Total audience reached was 108 with *all* participants completing the training (100%)
- About 98.1% of Know the Signs participants would agree or strongly agree that they would recommend this training to someone else

- Total of 19 trainings for FY 23-24
- Total audience reached was 327 participants with 314 participants completing the training (96.0%)
- On a scale of 1 (i.e., did not like) to 10 (i.e., liked a lot), participants (n=314) rated the quality of ASIST as 9.4 out of 10

ASIST

# MENTAL HEALTH FIRST AID (MHFA)

***Program Description***

The **Mental Health First Aid (MHFA)** program is an 8-hour long interactive session and can be conducted in three different ways: one-day 8-hour seminar, two-day 4-hour seminar, or a four-day 2-hour seminar. The program covers risk/protective factors, warning signs of mental health problems, prevalence data, stigma, assessment, intervention, and how to connect individuals in crisis with appropriate care.

Additionally, the MHFA program provides evidence-based professional, peer, social, and self-help resources for individuals with a mental health illness. For specific target populations, there are two courses that are offered for training and certification, the Adult MHFA and the Youth MHFA (YMHFA). Each certification must be renewed every three years.

***Program Objective:*** MHFA teaches about *recovery* and *resiliency*—the belief that individuals experiencing these challenges can and do get better because they utilize their strengths to stay well.

## FY 23-24 OVERVIEW

***FY 23-24 MHFA Training Overview Summary***

All **17 Adult MHFA and Youth MHFA trainings** were conducted in collaboration with **PEI, WET, Public Health, HelpLine, RUHS-BH Crisis, Moreno Valley College** and **other organizations**. Additionally, all trainings took place in either the **Western or Mid-County** regions. Specific audiences/groups that were targeted were the MHSA provider groups, law enforcement, as well as WET interns.

**17**
**Total Number of Trainings**

**231**
**Total Number Reached**

**225**
**Total Number Completed Training**

**6**
**Smallest Audience Size**

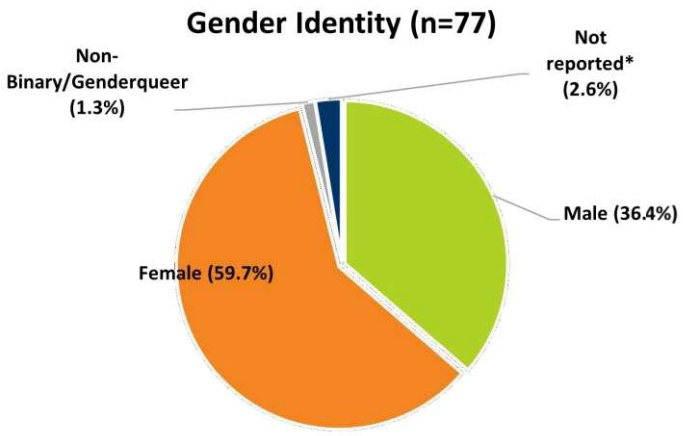
**28**
**Largest Audience Size**

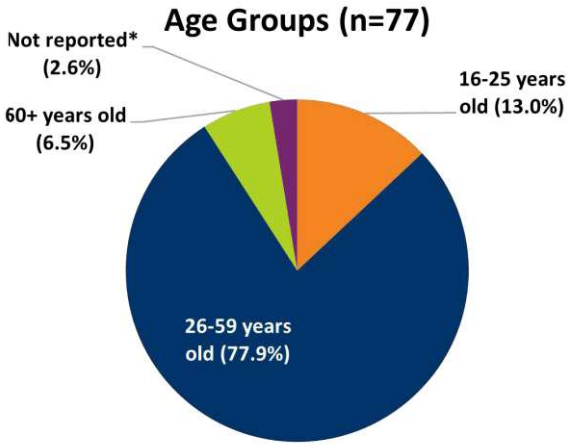
# MENTAL HEALTH FIRST AID (MHFA)

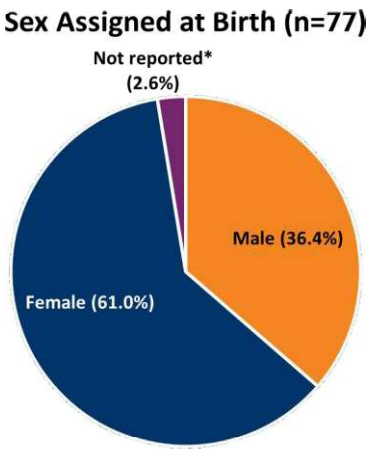
## ADULT MHFA DEMOGRAPHICS

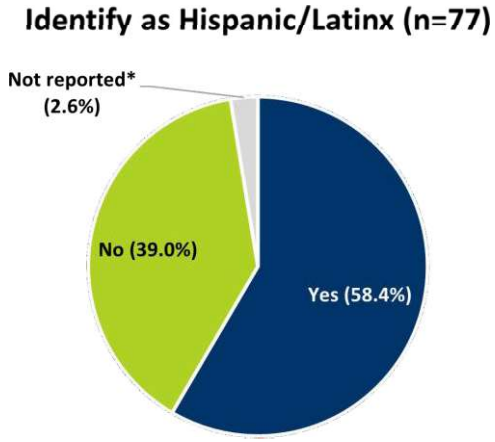
***Demographics Summary***

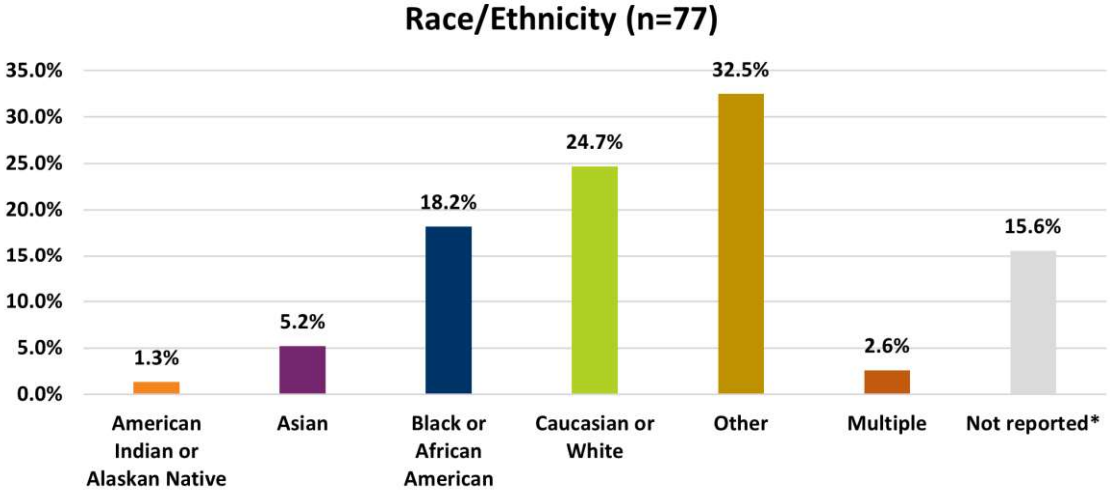
Most Adult MHFA participants identified their gender as **female (59.7%)** and half of the participants reported **female as their sex assigned at birth (61.0%)**. The majority of Adult MHFA participants were in the **26 to 59 years old age group (77.9%)**. Additionally, most participants identified as **Other (32.5%)** followed by White (24.7%), Black/African American (18.2%), Asian (5.2%), Multiple (2.6%) and American Indian or Alaskan Native (1.3%). More than half of participants identified as **Hispanic/Latinx (58.4%).**



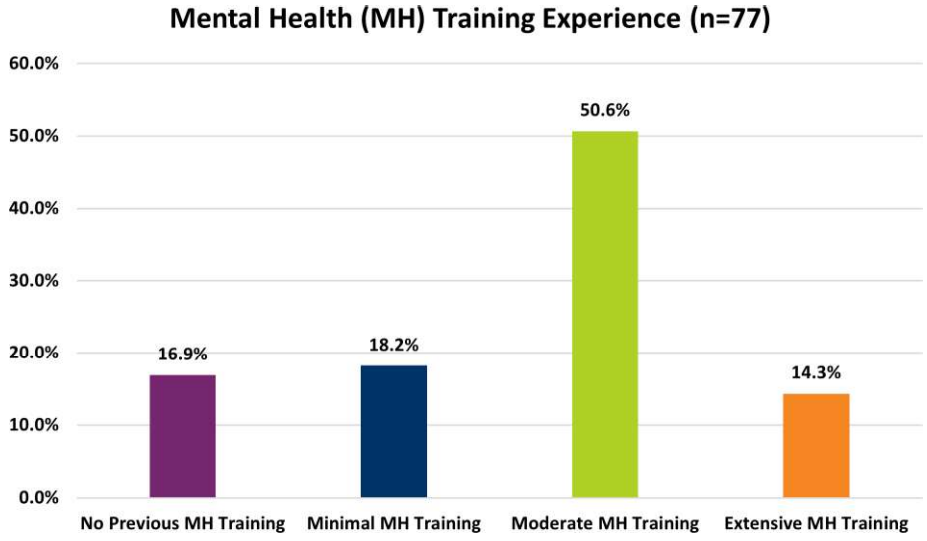

**Note:* "Not reported" includes individuals who chose not to answer.*

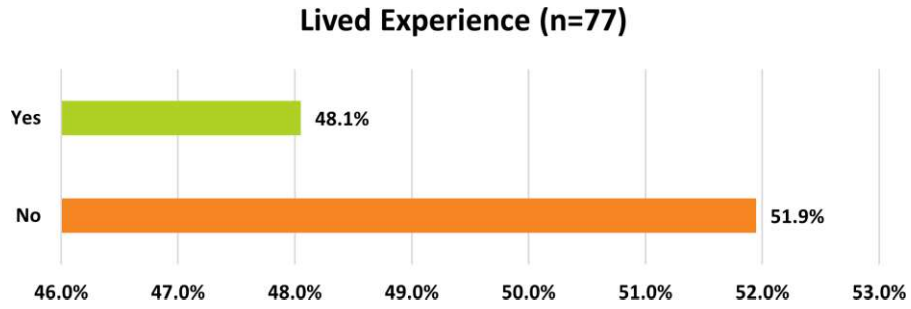
# MENTAL HEALTH FIRST AID (MHFA)

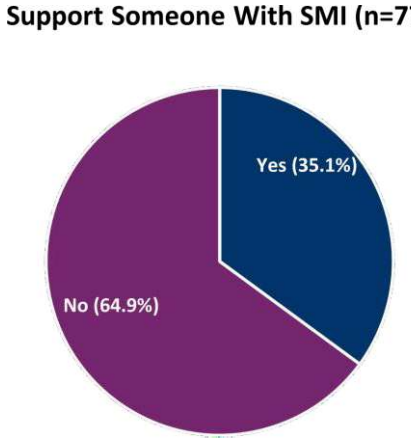
## ADULT MHFA DEMOGRAPHICS (cont.)

***Demographics Summary (cont.)***

Of the participants that reported their mental health level experience, about **50.6% of participants had reported that they had moderate mental health training**, which includes several workshops, trainings, or classes about mental health. In addition, about 51.9% of the participants reported that they do not identify as a person with lived experience or a person in long-term recovery. And lastly, over one-third of participants (35.1%) reported that they support a family member with lived experience, serious mental illness, or in long-term recovery.



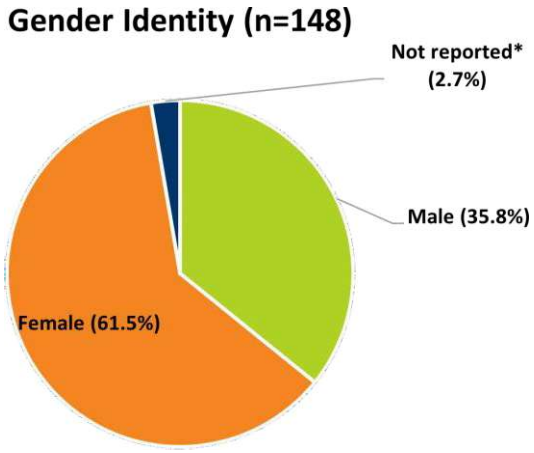

**Note:* *"Not reported" includes individuals who chose not to answer.*

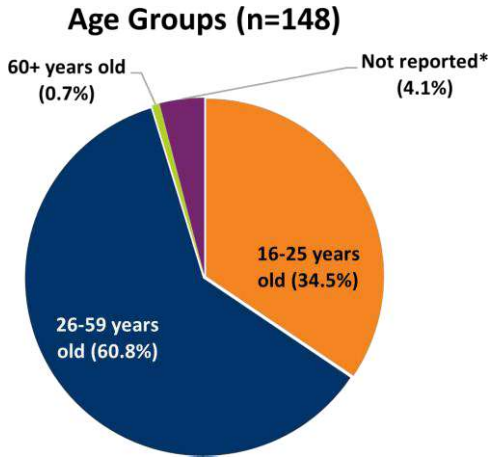
# MENTAL HEALTH FIRST AID (MHFA)

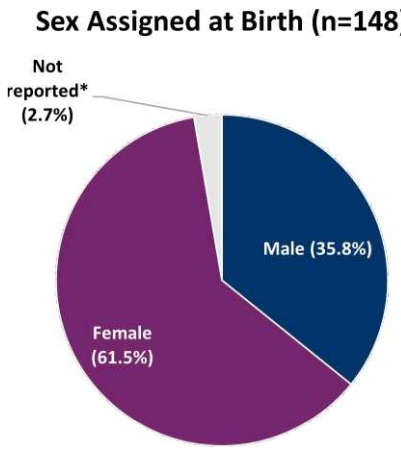
## YOUTH MHFA DEMOGRAPHICS

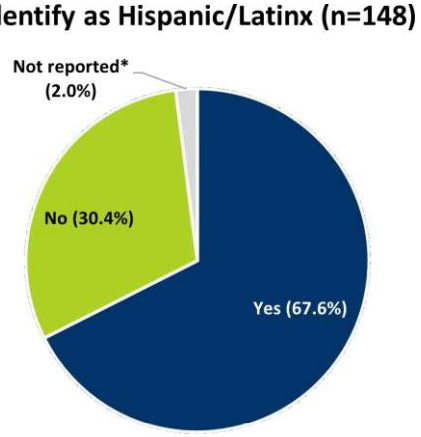
***Demographics Summary***

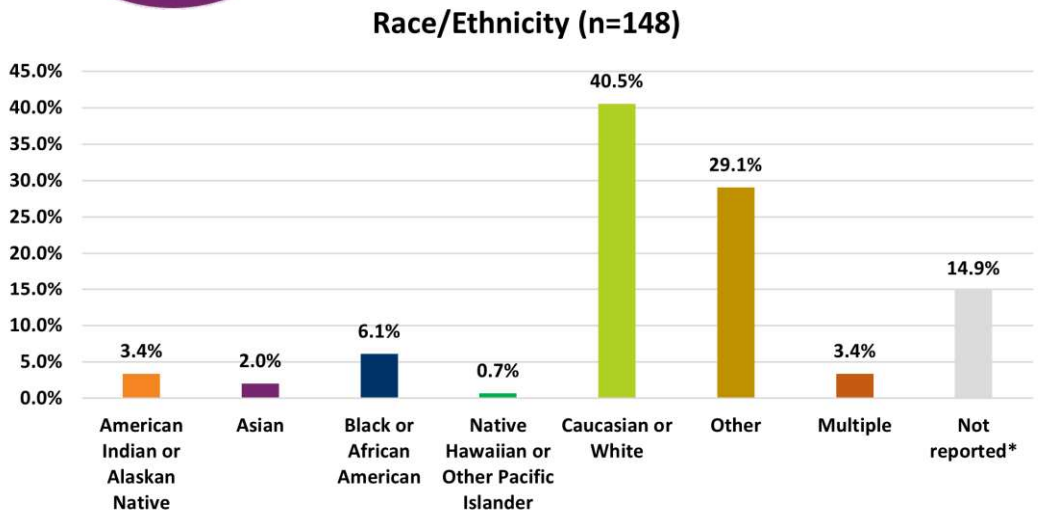
Most Youth MHFA participants identified their gender as **female (61.5%)** and half of the participants reported **female as their sex assigned at birth (61.5%)**. The majority of Youth MHFA participants were in the **26 to 59 years old age group (60.8%)**. Additionally, most participants identified as **White (40.5%)** followed by Other (29.1%), Black/African American (6.1%), Multiple (3.4%), American Indian or Alaskan Native (3.4%), Asian (2.0%), and Native Hawaiian or Other Pacific Islander (0.7%). More than half of participants identified as **Hispanic/Latinx (67.6%).**



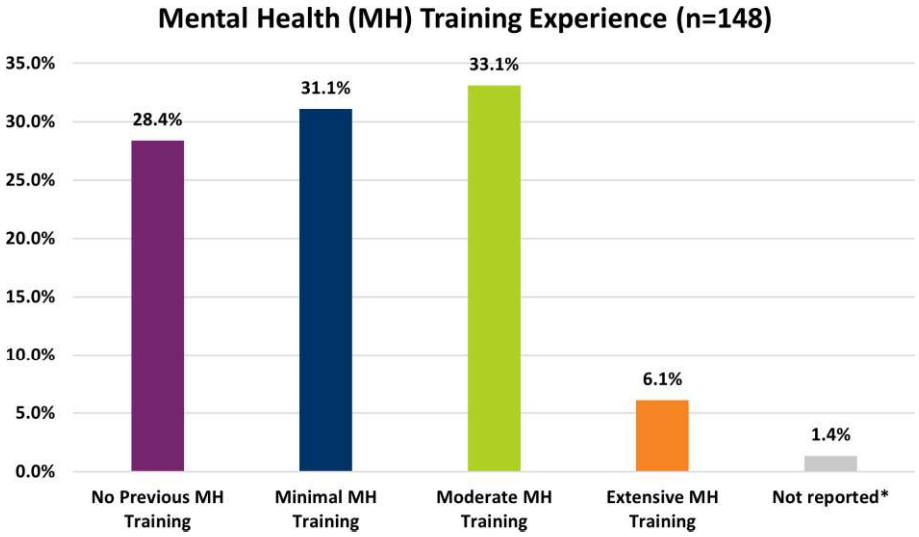

**Note:* "Not reported" includes individuals who chose not to answer.*

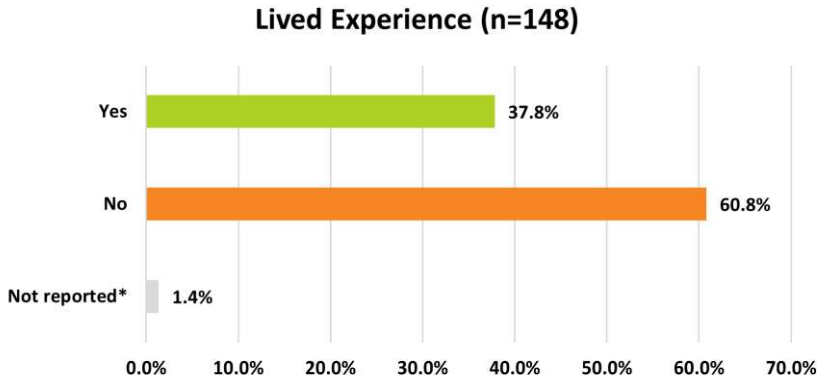
# MENTAL HEALTH FIRST AID (MHFA)

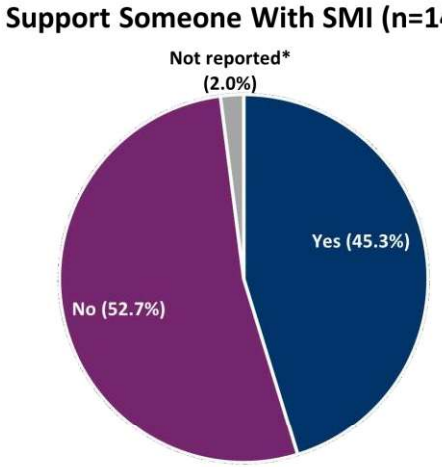
## YOUTH MHFA DEMOGRAPHICS

***Demographics Summary (cont.)***

Of the participants that reported their mental health level experience, about **33.1% of participants had reported that they had moderate mental health training**, which includes attending several workshops, trainings, or classes about mental health. In addition, **60.8% of participants reported that they do not identify as a person with lived experience** or a person in long-term recovery. And lastly, about **45.3% of participants reported that they support a family member** with lived experience, serious mental illness, or in long-term recovery.




**Note:* "Not reported" includes individuals who chose not to answer.*

# MENTAL HEALTH FIRST AID (MHFA)

## ADULT MHFA PRE/POST OUTCOMES

### *Adult MHFA Pre/Post Outcomes Summary*

As a part of the outcomes evaluation, the MHFA training requires individuals to complete a Mental Health First Aid Pre-Evaluation and Post-Evaluation form before and after the training.

Within the Pre and Post Evaluation forms, participants indicated to what extent they agree or disagree with specific statements regarding various mental health concepts. There were a total of **76 individuals** who completed both the Pre and Post measures from the Adult and Youth MHFA trainings. The Pre and Post scores from the evaluation forms are shown on the next page with their respective questions shown down below.

| |
|---|
| **Your Beliefs About Mental Health and Substance Use (1=Strongly Disagree; 2=Somewhat Disagree; 3=Neither Agree nor Disagree; 4=Somewhat Agree; 5=Strongly Agree)** |
| **1. In general, I believe that…** |
| 1a. I intend to take action to help anyone I work with to address their mental health or substance use challenge(s). |
| 1b. I intend to reach out and express my concerns to anyone I work with that might be experiencing mental health or substance use challenge(s). |
| 1c. I intend to listen without expressing my judgement to anyone I suspect of experiencing a mental health or substance use challenge(s). |
| **Your Beliefs About Mental Health First Aid Actions (1=Not Difficult At All; 2=Somewhat Not difficult; 3=Unsure; 4=Somewhat Difficult; 5=Extremely Difficult)** |
| **2. Currently I believe that for me…** |
| 2a. Giving practical resources (e.g., self-help information, crisis hotline number) to anyone showing signs and symptoms of a mental health or substance use challenge(s) is: |
| 2b. Referring anyone experiencing a mental health or substance use challenge(s) to a health professional is: |
| **Your Beliefs About Mental Health First Aid Actions (1=Extremely Unlikely; 2=Somewhat Unlikely; 3=Neither Likely Nor Unlikely; 4=Somewhat Likely; 5=Extremely Likely)** |
| **3. For each statement below, please circle the response that best describes your opinion.** |
| 3a. If I express my concerns to any person about the mental health signs and symptoms that they are experiencing, it will help that person to seek timely support. |
| 3b. If I give information about mental health professionals in the community to any person experiencing mental health or substance use challenge(s), it will assist that person to get help. |
| **Your Confidence in Performing Mental Health Actions (1=Strongly Disagree; 2=Somewhat Disagree; 3=Neither Agree nor Disagree; 4=Somewhat Agree; 5=Strongly Agree)** |
| **4. Currently, I am confident that I can…** |
| 4a. Have a supportive conversation with anyone about mental health or substance use challenges. |
| 4b. Ask anyone directly whether they are considering killing themselves. |
| 4c. Respond to a substance use crisis including an overdose and know what to do keep an individual safe. |

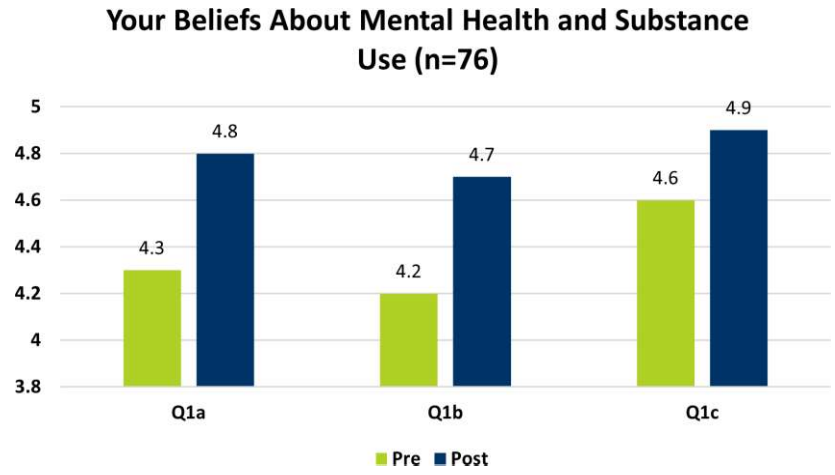
**Note: Pre and Post analysis was only conducted for individuals who completed both measures.*

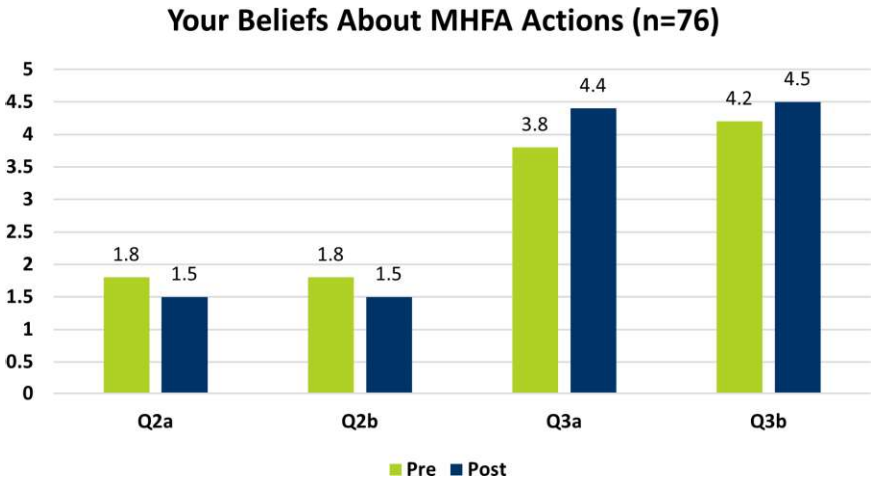
# MENTAL HEALTH FIRST AID (MHFA)

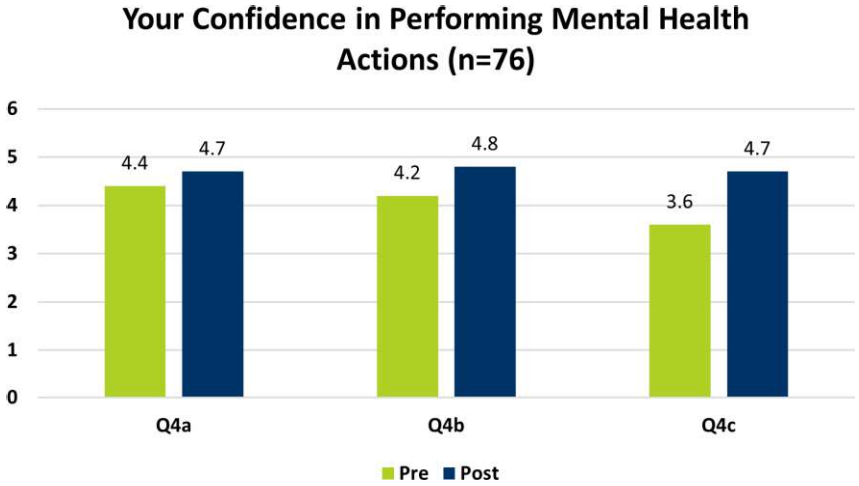
## ADULT MHFA PRE/POST OUTCOMES

***Adult MHFA Pre/Post Outcomes Summary (cont.)***

Across all domains, the majority of participants had increased confidence, knowledge, and intention in helping individuals who may be experiencing a mental health crisis. It should be noted that questions 2a and 2b asked individuals how *difficult* it might be to perform MHFA actions. Participants responded that there was an overall decrease in difficulty in conducting those actions after completing the training.



# MENTAL HEALTH FIRST AID (MHFA)

## YOUTH MHFA PRE/POST OUTCOMES

***Youth MHFA Pre/Post Outcomes Summary***

Similar to the requirement made for Adult MHFA, as a part of the outcomes evaluation, the MHFA training requires individuals to complete a Mental Health First Aid Pre-Evaluation and Post-Evaluation form before and after the training.

Within the Pre and Post Evaluation forms, participants indicated to what extent they agree or disagree with specific statements regarding various mental health concepts. The Pre and Post scores from the evaluation forms are shown on the next page with their respective questions shown down below.

| |
|---|
| **Your Beliefs About Mental Health and Substance Use (1=Strongly Disagree; 2=Somewhat Disagree; 3=Neither Agree nor Disagree; 4=Somewhat Agree; 5=Strongly Agree)** |
| **1. In general, I believe that…** |
| 1a. I intend to take action to help anyone I work with to address their mental health or substance use challenge(s). |
| 1b. I intend to reach out and express my concerns to anyone I work with that might be experiencing mental health or substance use challenge(s). |
| 1c. I intend to listen without expressing my judgement to anyone I suspect of experiencing a mental health or substance use challenge(s). |
| **Your Beliefs About Mental Health First Aid Actions (1=Not Difficult At All; 2=Somewhat Not difficult; 3=Unsure; 4=Somewhat Difficult; 5=Extremely Difficult)** |
| **2. Currently I believe that for me…** |
| 2a. Giving practical resources (e.g., self-help information, crisis hotline number) to anyone showing signs and symptoms of a mental health or substance use challenge(s) is: |
| 2b. Referring anyone experiencing a mental health or substance use challenge(s) to a health professional is: |
| **Your Beliefs About Mental Health First Aid Actions (1=Extremely Unlikely; 2=Somewhat Unlikely; 3=Neither Likely Nor Unlikely; 4=Somewhat Likely; 5=Extremely Likely)** |
| **3. For each statement below, please circle the response that best describes your opinion.** |
| 3a. If I express my concerns to any person about the mental health signs and symptoms that they are experiencing, it will help that person to seek timely support. |
| 3b. If I give information about mental health professionals in the community to any person experiencing mental health or substance use challenge(s), it will assist that person to get help. |
| **Your Confidence in Performing Mental Health Actions (1=Strongly Disagree; 2=Somewhat Disagree; 3=Neither Agree nor Disagree; 4=Somewhat Agree; 5=Strongly Agree)** |
| **4. Currently, I am confident that I can…** |
| 4a. Have a supportive conversation with anyone about mental health or substance use challenges. |
| 4b. Ask anyone directly whether they are considering killing themselves. |
| 4c. Respond to a substance use crisis including an overdose and know what to do keep an individual safe. |

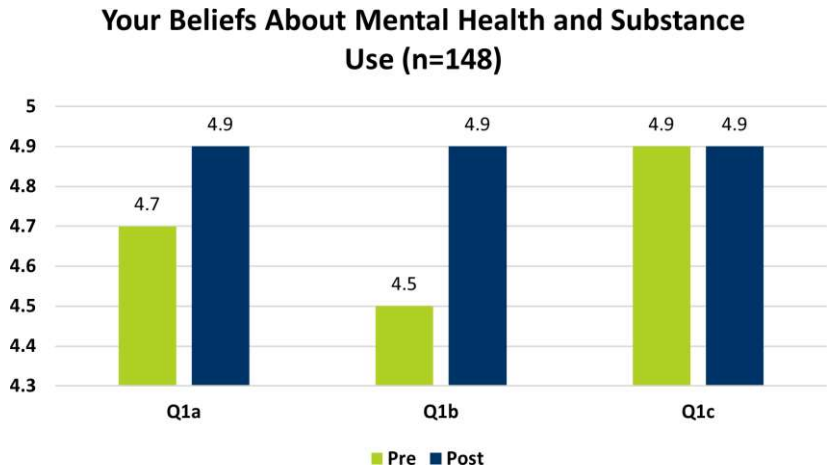
**Note:* Pre and Post analysis was only conducted for individuals who completed both measures.*

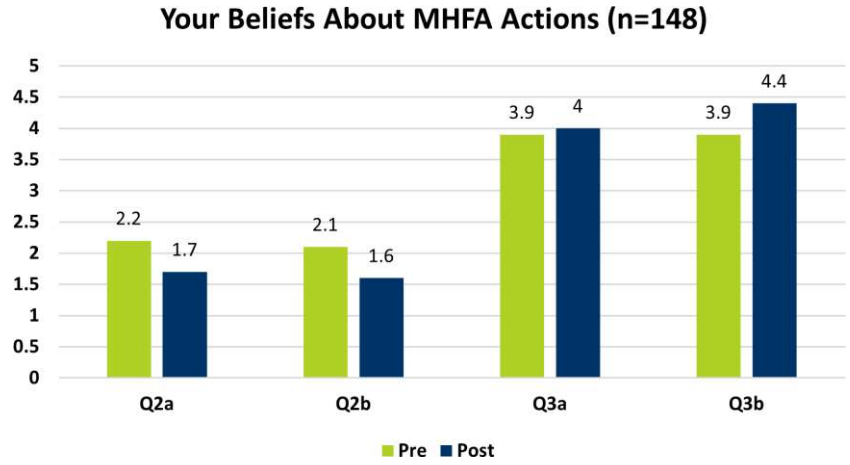
# MENTAL HEALTH FIRST AID (MHFA)

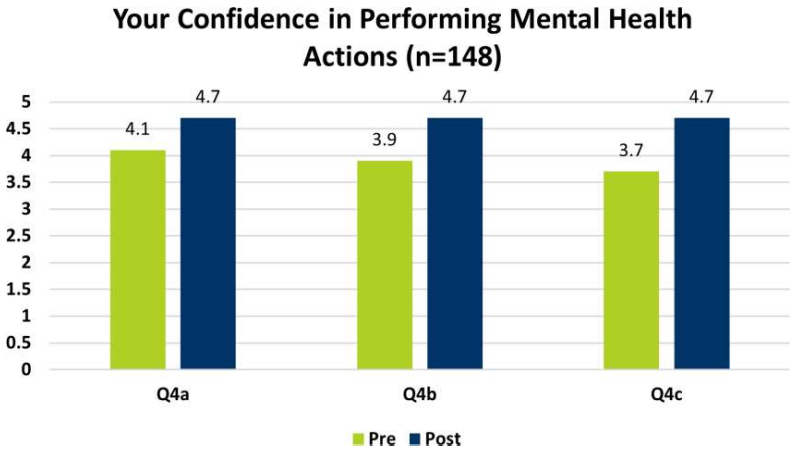
## YOUTH MHFA PRE/POST OUTCOMES

***Youth MHFA Pre/Post Outcomes Summary (cont.)***

Similar to the results shown in the Adult MHFA Pre/Post Outcomes, across all domains, the majority of Youth MHFA participants had increased confidence, knowledge, and intention in helping youth who may be experiencing a mental health crisis. It should be noted that questions 2a and 2b asked individuals how *difficult* it might be to perform MHFA actions, and participants responded that there was an overall decrease in difficulty in conducting those actions after completing the training.



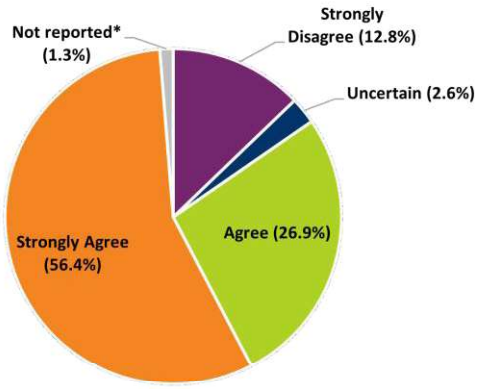
# MENTAL HEALTH FIRST AID (MHFA)

## ADULT MHFA OVERALL SATISFACTION

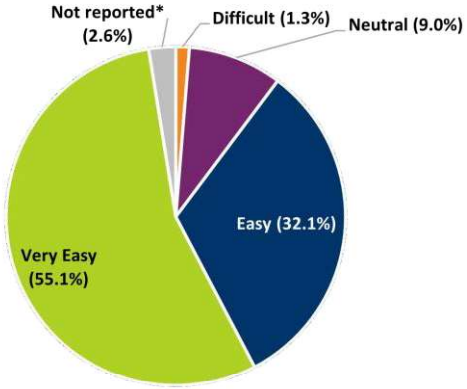
### *Adult MHFA Satisfaction Summary*

Participants are also asked to complete a program evaluation feedback form at the end of the training. Some of the responses to the satisfaction questions are shown below. Individuals reported that they **strongly agree (54.4%)** that there was an adequate opportunity in practicing their skills that they learned from the training. More than half of the participants found that navigating the coursework was **very easy (55.1%)**. Additionally, more than half of the respondents found that the existing scenarios from the training were **very relevant (76.9%)** to the populations that they primarily work with and about **67.9%** indicated that the pace of the coursework was **neutral**. Although not shown below, a great majority said yes to **taking another MHFA course (97.4%).**

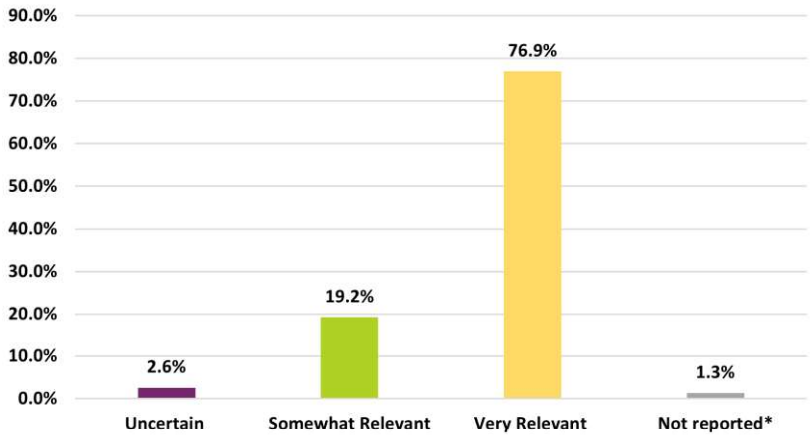
**Adequate Opportunity to Practice Skills Learned (n=78)**



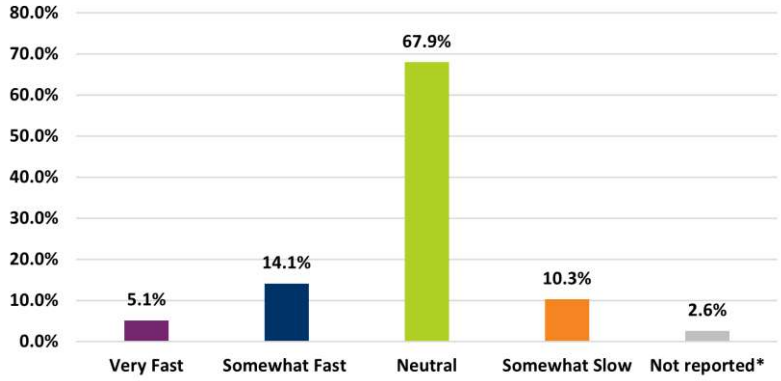

**Overall Experience Navigating Coursework (n=78)**




**How Relevant the Existing Scenarios Are (n=78)**




**Pace of the Coursework (n=78)**



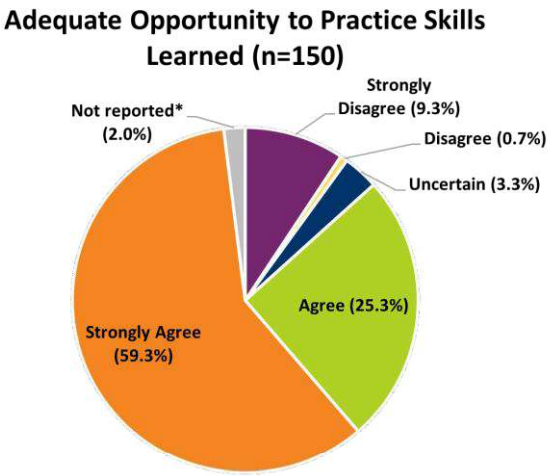

**Note:* *"Not reported" includes individuals who chose not to answer.*

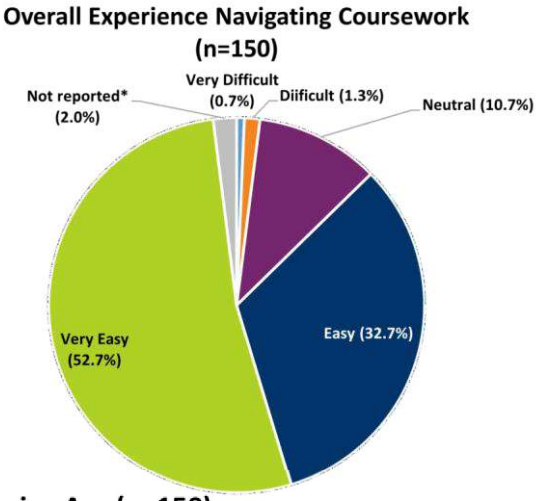
# MENTAL HEALTH FIRST AID (MHFA)

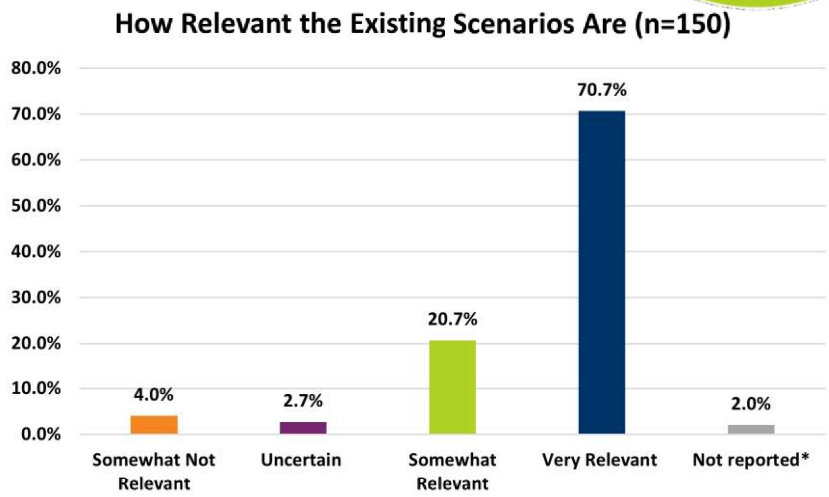
## YOUTH MHFA OVERALL SATISFACTION

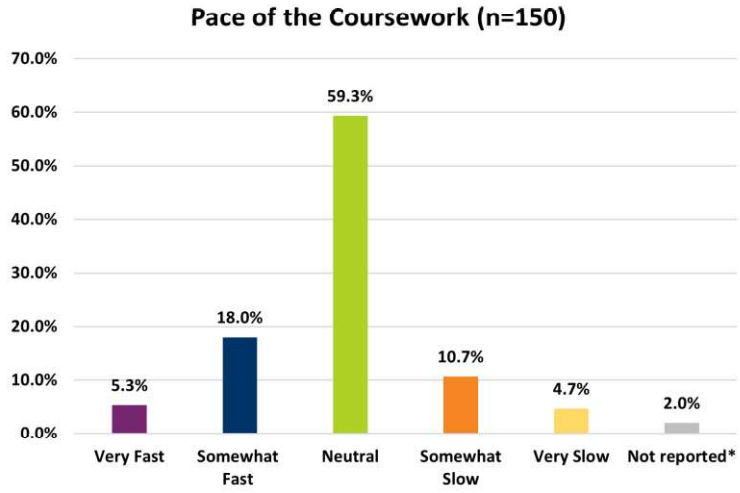
***Youth MHFA Satisfaction Summary***

Individuals reported that they **strongly agree (59.3%)** that there was an adequate opportunity in practicing their skills that they learned from the training. Almost half of the participants found that navigating the coursework was very **easy (52.7%)**. Additionally, more than half of the respondents found that the existing scenarios from the training were **very relevant (70.7%)** to the populations that they primarily work with and about **59.3%** indicated that the pace of the coursework was **neutral**. Although not shown below, a majority said yes to **taking another MHFA course (90.7%).**




**Note:* *"Not reported" includes individuals who chose not to answer.*

# MENTAL HEALTH FIRST AID (MHFA)

## ADULT & YOUTH MHFA ADDITIONAL COMMENTS

### *Adult MHFA and Youth MHFA Quiz Outcomes*

To complete a MHFA training, participants were required to take the Adult MHFA Quiz, which evaluates participants' understanding of the MHFA program, overall knowledge, stigmatizing attitudes, and helping behaviors in assisting someone experiencing a mental health or substance use condition. The quiz is taken at the end of the training and a score of 6 out of 10 is required to pass the course. **For FY 23-24, all 225 Adult and Youth MHFA participants passed the quiz with a rate of 100%.**

### *Adult & Youth MHFA Additional Comments Summary*

Below are the participants' comments from the program evaluation feedback forms. These comments highlight the importance of the program and other thoughts that participants had about the overall program, instructors, and training.

*"I appreciated reading closely about a disorder and sharing findings with the group."*

*"Thank you for the examples on how we may respond to specific situations."*

*What Was Most Helpful About the Course?*

*"Knowing how to approach & speak to someone in crisis."*

*"Very friendly, warm, welcoming, supportive and awesome!"*

*"Loved both instructors, both of their styles went well together. I appreciate how realistic they are too. Thank you."*

# SAFETALK

## *Program Description*

**safeTALK** is a half-day training program that teaches participants to recognize and engage with individuals who possibly have suicidal thoughts and to connect them with community resources. safeTALK emphasizes safety while challenging the stigma in openly discussing suicide. It is recommended that individuals trained in ASIST or other suicide prevention programs to be at all safeTALK trainings.

This program provides gradual exposure to practice actions and to help participants understand how false societal beliefs can cause otherwise caring and helpful people to miss, dismiss, or avoid warning signs of suicide. Additionally, 'Safe' stands for 'Suicide Alertness For Everyone' and 'TALK' stands for 'Tell, Ask, Listen, and KeepSafe'. This program helps participants practice the TALK step actions in overcoming these barriers.

***Program Objective:*** To learn how to prevent suicide by recognizing signs, engaging someone, and connecting them to an intervention resource for further support.

## FY 23-24 OVERVIEW

### *FY 23-24 safeTALK Training Overview Summary*

For FY 23-24, there were a total of **503 individuals** who completed the safeTALK training. All **31 safeTALK trainings** were conducted in collaboration with **RUHS-BH PEI staff** and many other departments, such as **RUHS-Public Health, HelpLine, Loma Linda Health University, Special Service for Groups—Asian Pacific Counseling & Treatment Center (SSG-APCTC),** and **WET.** Additionally, most trainings took place in the **Western region**, while a few were conducted in **San Bernardino County**.

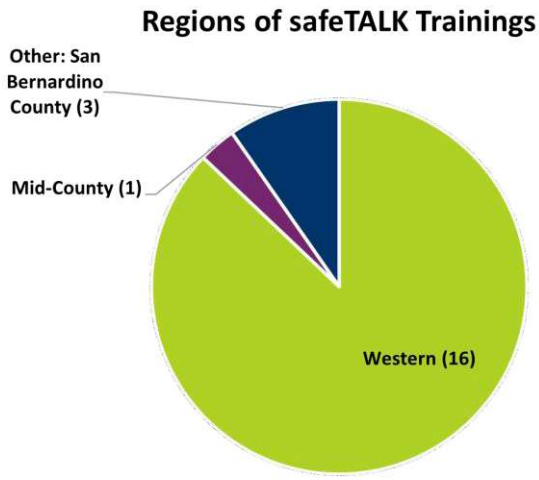
**31**
**Total Number of Trainings**

**503**
**Total Number Reached**

**503**
**Total Number Completed Training**

**4**
**Smallest Audience Size**

**37**
**Largest Audience Size**

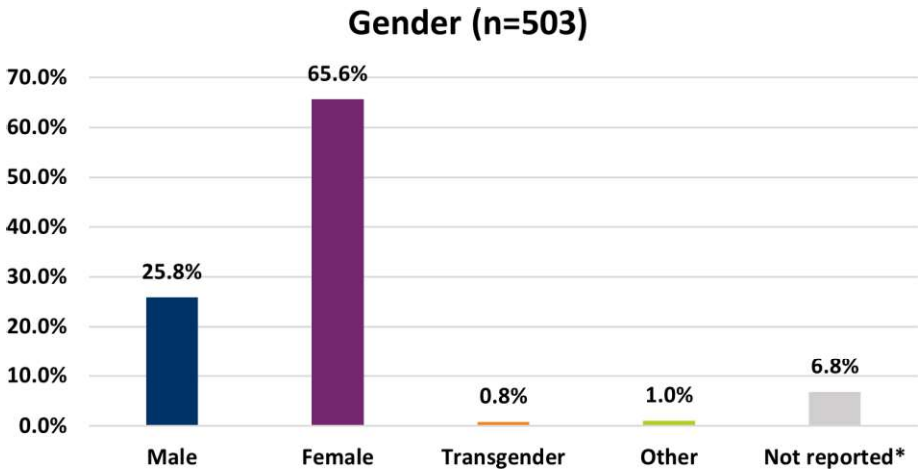

Regions of safeTALK Trainings
Other: San Bernardino County (3)
Mid-County (1)
Western (16)

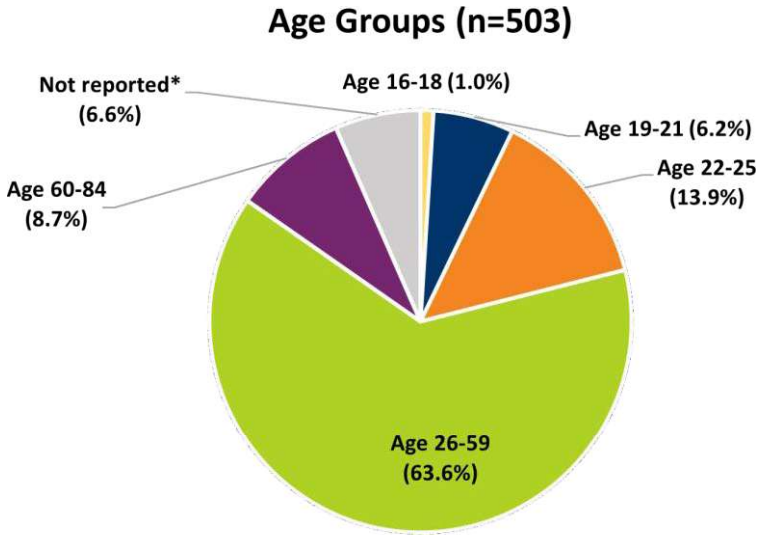
# SAFETALK

## DEMOGRAPHICS

***Demographics Summary***

More than half of the safeTALK participants identified as **female (65.6%)**, followed by male (25.8%), transgender (0.8%), and other (1.0%). In addition, most of the participants were in the **26-59 age group (63.6%)**, followed by the 22-25 age group (13.9%), 60-84 age group (8.7%), 19-21 age group (6.2%), and 16-18 age group (9.1%).




**Note:* "Not reported" includes individuals who chose not to answer.*

# SAFETALK

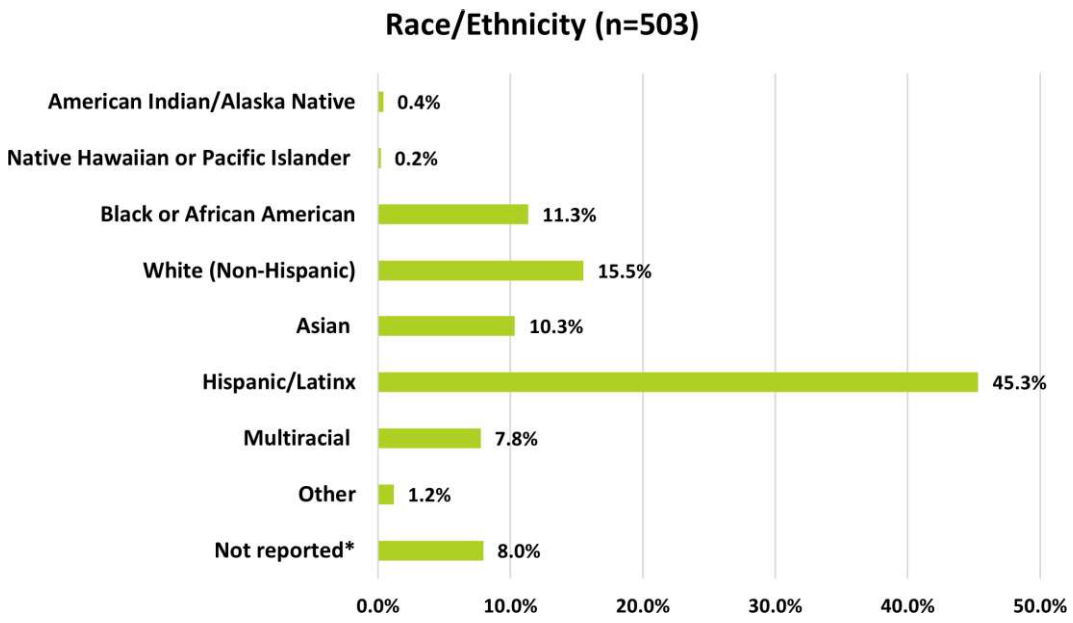
## DEMOGRAPHICS

***Demographics Summary***

The majority of participants identified as **Hispanic/Latinx (45.5%)**, followed by White—Non Hispanic (15.5%), Black or African American (11.3%), Asian (10.3%), Multiracial (7.8%), Other (1.2%), American Indian/Alaska Native (0.4%), and Native Hawaiian or Pacific Islander (0.2%). Additionally, 8.0% of participants chose to not answer the race/ethnicity question and are included in the "not reported" category down below.

Individuals reported that they **work in a mental health care setting (22.1%),** followed by working in a school or university (16.3%), other setting (16.1%), more than one setting (11.7%), medical care setting (8.9%), and religious organization setting (2.2%).

The safeTALK trainings reached out to a diverse range of audience groups; however, the most frequent type of audience that was reported are individuals from the **community at large (35.4%)** Some examples of "other" groups include folks from nonprofit organizations, training centers, etc. Although not shown here, most participants reported that they **do not have a disabling condition (87.9%)** and that they are **not a veteran (90.5%)**. Lastly, **safeTALK participants reported that did not identify as being a part of the LGBTQ+ community (82.5%).**




| Type of Work Environment | Count | Percentage |
|---|---|---|
| School/University | 82 | 16.3% |
| Mental Health Care Setting | 111 | 22.1% |
| Medical Care Setting | 45 | 8.9% |
| Religious Organizations | 11 | 2.2% |
| Other | 81 | 16.1% |
| More than 1 | 59 | 11.7% |
| Not reported* | 114 | 22.7% |
| **Total** | **503** | **100.0%** |

| Type of Audience Reached | Count | Percentage |
|---|---|---|
| An interested parent | 41 | 8.2% |
| Consumer of services | 47 | 9.3% |
| Community at large | 178 | 35.4% |
| Other | 122 | 24.3% |
| More than 1 | 67 | 13.3% |
| Not reported* | 48 | 9.5% |
| **Total** | **503** | **100.0%** |

**Note:* "Not reported" includes individuals who chose not to answer.*

# SAFETALK

## EVALUATION OUTCOMES

***Evaluation Outcomes Summary***

All safeTALK participants are asked to complete a feedback form at the end of the training presentation to complete their training. The feedback form includes questions about participant satisfaction of the training and any additional comments that participants would like the safeTALK program to know.

| **Please circle the choice that best describes your response *(1=Strongly Disagree, 2=Partly Agree, 3=Agree, 4=Strongly Agree; n=503).**** | | | | |
|---|---|---|---|---|
| **Questions** | **Responses** | | | |
| | **1** | **2** | **3** | **4** |
| 1. My trainer was prepared and familiar with the material. | ** | 0.4% | 7.8% | 91.7% |
| 2. My trainer encouraged participation and respected all responses. | ** | 0.4% | 4.4% | 94.8% |
| 3. I intend to tell others that they will benefit from this training: | ** | 1.0% | 9.9% | 86.9% |
| **Please circle the choice that best describes your response *(1=Not Prepared, 2=Partly Prepared, 3=Mostly Prepared, 4=Well Prepared; n=503).**** | | | | |
| **Questions** | **Responses** | | | |
| | **1** | **2** | **3** | **4** |
| 4. How prepared do you now feel to talk directly and openly to a person about their thoughts of suicide? | ** | 1.8% | 32.6% | 64.2% |
| **On a scale of 1 *(i.e., very bad)* to 10 *(i.e., very good)*, how would you rate this training *(n=503)*?** | | | | |
| 5. How would you rate this training? | **Average Rating (Mean)** | | | 9.6 |

**Total percentage may not equal to 100% due to "not reported" data which is not shown here.*

***No responses.*

## SAFETALK ADDITIONAL COMMENTS

*"This training helped my school community to not be afraid and it [the training] will help them build capacity within their role."*

*"Going over the slides and having the videos were helpful to understand the steps. Resource are also very helpful and useful to provide to others who are in need."*

*"Very informative, kept my attention & was engaging which made it more comfortable to speak out & participate."*

# KNOW THE SIGNS

***Program Description***

**Know the Signs** is a statewide suicide prevention social marketing campaign built on three key messages: *"Know the signs. Find the words. Reach out."* This campaign is intended to educate on how to recognize the warning signs of suicide, how to find the words to have a direct conversation with someone in crisis, and where to find professional help and resources.

The campaign has specifically designed culturally relevant posters to help communities in understanding the message. The posters and marketing materials are available in English, Spanish, Vietnamese, Korean, Hmong, Khmer, Lao, Mandarin, Tagalog, Punjabi and Russian. There are also print ads, TV and radio spots, and online ads available for the public. At the end of each presentation, everyone is encouraged to download the mobile application to help connect at -risk individuals to a supportive network.

***Program Objective:*** Know the Signs has the overarching goal to increase Californians' capacity to prevent suicide by encouraging individuals to know the signs, find the words to talk to someone they are concerned about, and to reach out to resources.

## FY 23-24 OVERVIEW

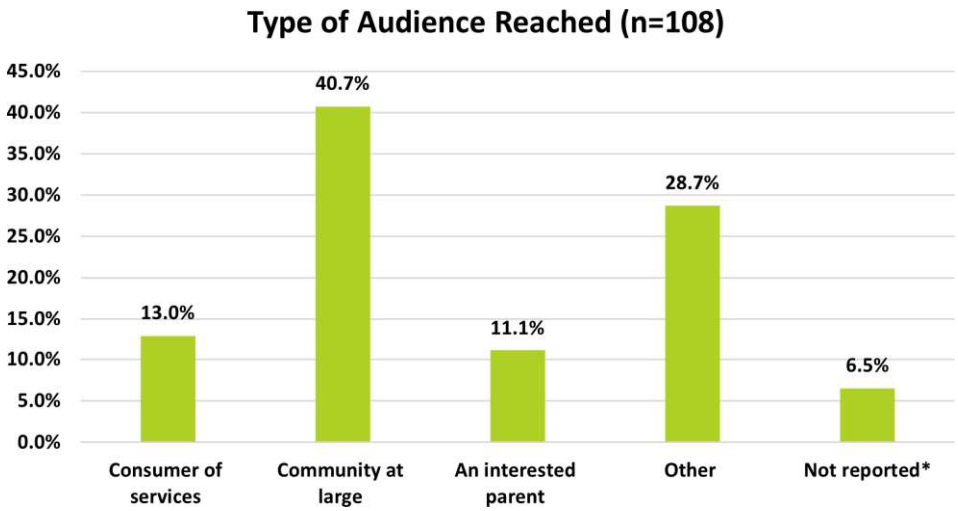
***FY 23-24 Know the Signs Training Overview Summary***

FY 23-24, there were a total of **17 trainings** and a total of **141 participants** who completed the training. In addition, for the type of audience reached, almost half of the Know the Signs participants identified as the **community at large (40.7%)**.

**17**
**Total Number of Trainings**

**108**
**Total Number Reached**

**108**
**Total Number Completed Training**



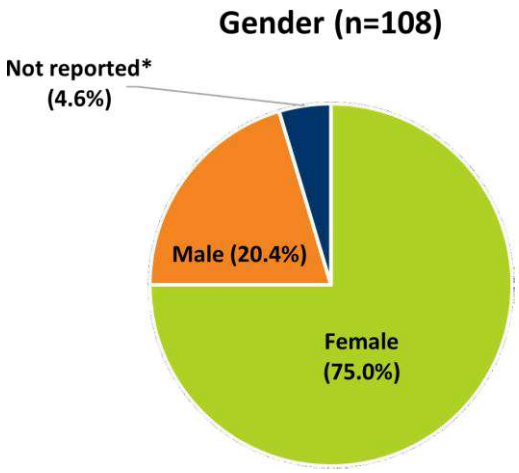

**Note:* "Not reported" includes individuals who chose not to answer.*

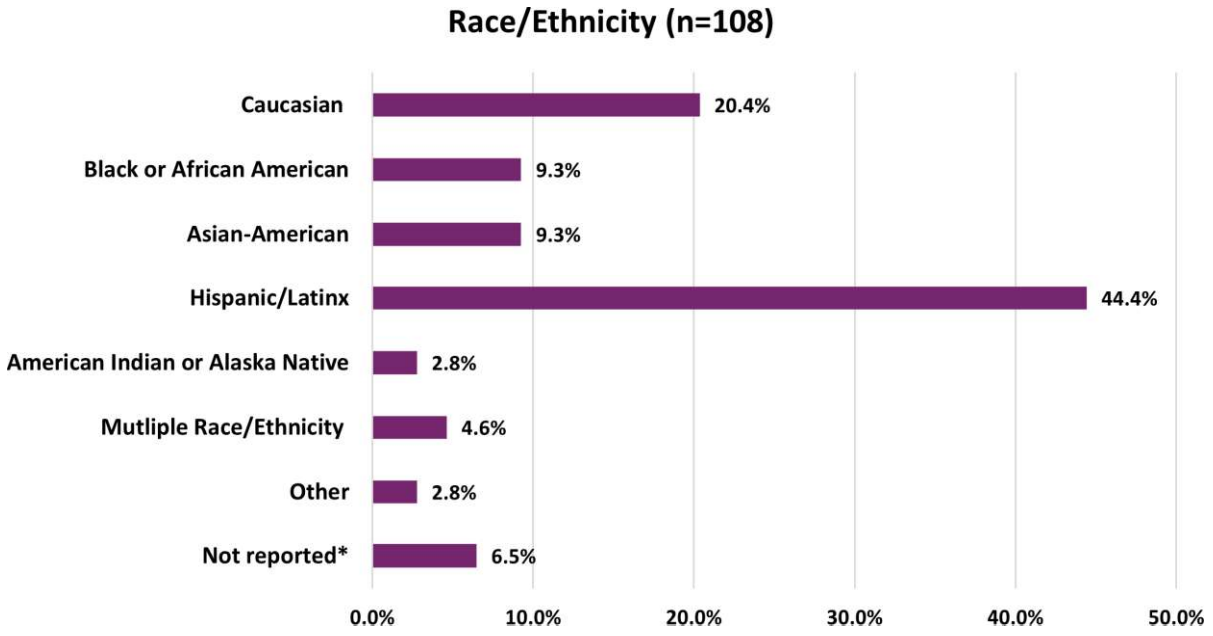
# KNOW THE SIGNS

## DEMOGRAPHICS

***Demographics Summary***

All demographic data includes participants from both the English and Spanish-speaking Know the Signs trainings. The majority of participants identified themselves as **female (75.0%)**, followed by males (20.4%). Additionally, most Know the Signs participants identified as **Hispanic/Latinx (44.4%)**, followed by Caucasian (20.4%%), Black or African American (9.3%), Asian-American (9.3%), Multiple Race/Ethnicity (4.6%), and American Indian or Alaska Native (2.8%), and Other (2.8%).




**Note:* "Not reported" includes individuals who chose not to answer.*

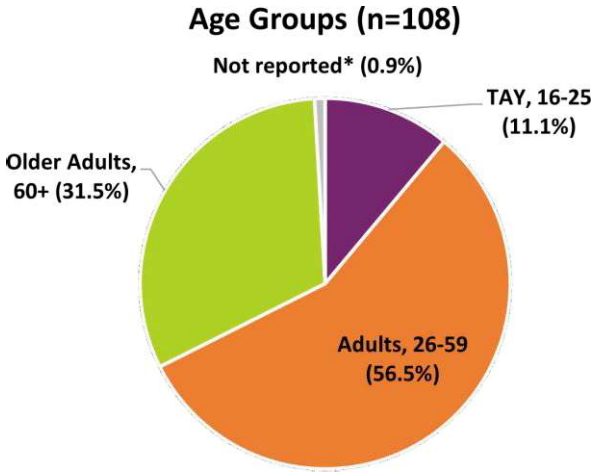
# KNOW THE SIGNS

## DEMOGRAPHICS (cont.)

***Demographics Summary (cont.)***

Most participants from the Know the Signs training reported that they were in the **26-59 age group (56.5%)**, followed by the 60+ age group (31.5%), and the 16-25 TAY age group (11.1%). About 0.9% of participants did not report their age resulting in some unknown data.

In addition, a great majority of Know the Signs participants reported **English as their preferred language (89.8%)**. Most Know the Signs participants reported that they **did not have a disability (86.1%) nor did they identify as a veteran (88.9%)**. Lastly, a majority of respondents indicated that they **did not identify as lesbian, gay, bisexual, or queer (LGBQ) (71.3%)** as their sexual orientation status.




| Demographic Characteristic | Percentage |
|---|---|
| ***Preferred Language (n=108)*** | |
| *English* | 89.8% |
| *Spanish* | 5.6% |
| *Not reported** | 3.7% |
| ***Disability (n=108)*** | |
| *Yes* | 7.4% |
| *No* | 86.1% |
| *Not reported** | 6.5% |
| ***Veteran Status (n=108)*** | |
| *Yes* | 4.6% |
| *No* | 88.9% |
| *Not reported** | 6.5% |
| ***LGBQ Sexual Orientation Status (n=108)*** | |
| *Yes* | 11.1% |
| *No* | 71.3% |
| *Not reported** | 14.8% |

**Note:* "Not reported" includes individuals who chose not to answer.*